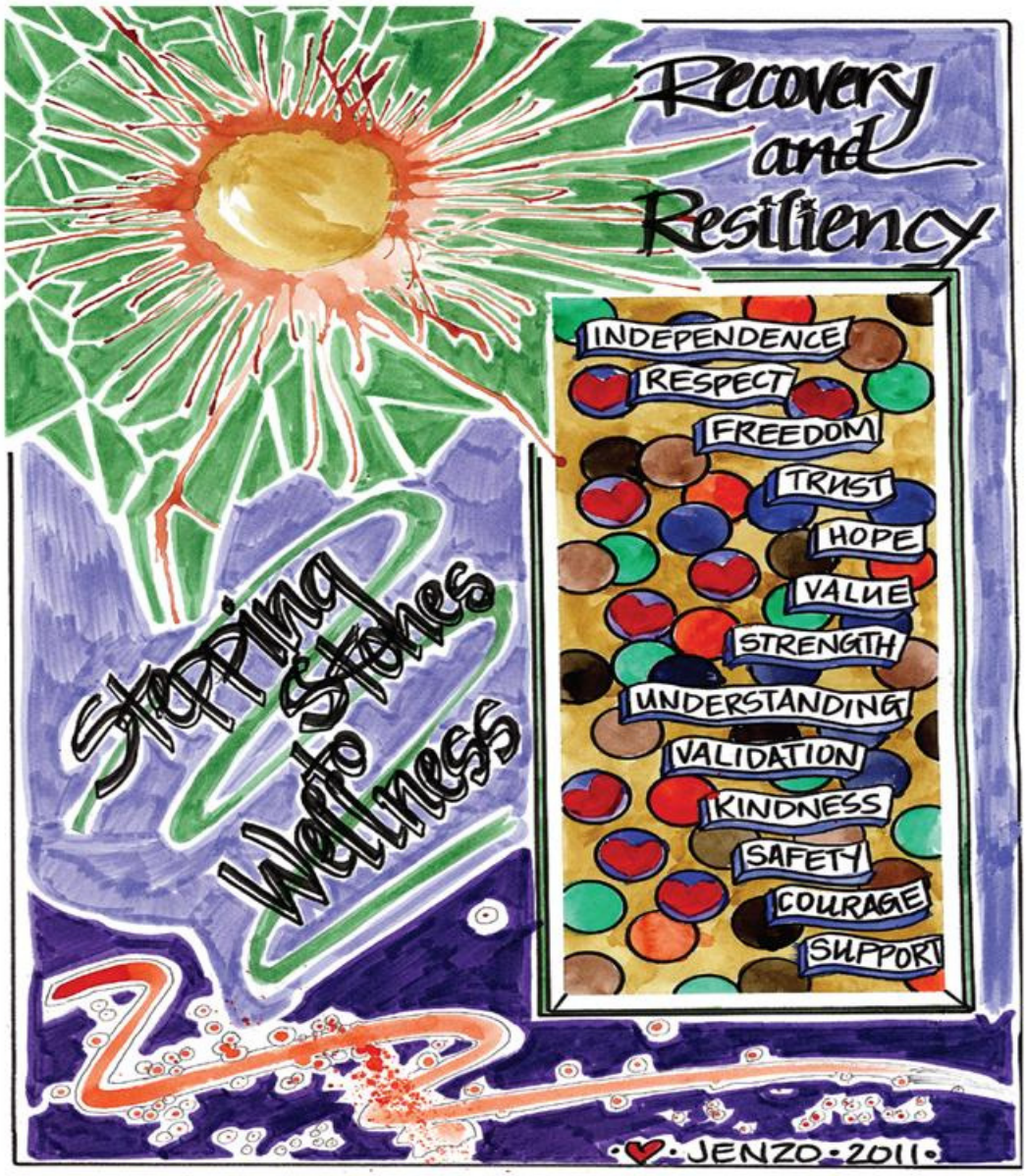
King County Mental Health, Chemical Abuse and Dependency Services Division

2010 Chemical Dependency Performance Indicator Report



Creating a Recovery Oriented System of Care

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From the Desk of Jim Vollendroff…

We are at a juncture in the delivery of substance abuse services in King County. Between parity legislation and health reform efforts in this county, the landscape is shifting for all health related services. King County and the King County contracted provider network are extremely fortunate to be building on a long history of innovation. We are well positioned to meet the challenges that we face in this new era of healthcare. Although we continue to be challenged with budget reductions, federal grants have been secured to continue to move the system forward and to increase the overall quality of services.

The King County Chemical Dependency Performance Indicator Report (CDPIR) is intended to inform the community of the Division's strategic vision and how the services we deliver align with the larger King County Strategic Plan in the areas of Justice and Safety and Health and Human Potential. This report also informs the public about our service delivery model and strategic vision for service delivery. The King County substance abuse treatment delivery system works in partnership with other departments within the county, the City of Seattle, and the Washington State Division of Behavioral Health and Recovery to plan and implement substance abuse programs for low income and indigent citizens within the community. King County Mental Health Chemical Abuse and Dependency Services Division (MHCADSD) provides drug and alcohol treatment through two mechanisms. A small number of services are provided directly by county staff, while the majority is provided through contracts with community treatment agencies.

We are committed to providing quality substance abuse services. Our mission is to foster and support an effective system of prevention, intervention, treatment and recovery support.

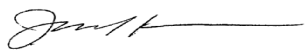
Our core values include:

- Equitable access
- Culturally and ethnically competent care
- Services based on scientific research and nationally recognized standards
- Strength-based and asset-based services for children, youth and families
- Partnership with allied community services to ensure quality services, supports and outcomes
- Accountability to those who are served in the system of care as well as the public at large
- Community inclusion, partnerships and collaboration

- Holistic approaches towards care

We are continuously evaluating and updating the service delivery model. We recognize that recovery from addiction is a change process through which an individual achieves abstinence and improved health, wellness and quality of life. We embrace the elements of a Recovery Oriented System of Care (ROSC). This system supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities and empowers them to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems.

The programs provided through MHCADSD are consistent with the King County Strategic Plan goal of promoting opportunities for all communities and individuals to realize their full potential and the goal of service excellence. King County looks forward to your partnership as we move ahead with transforming today's substance abuse system of care to a ROSC, and move toward the greater integration of services called for by health care reform.



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King County Mental Health Chemical Abuse and Dependency Services Division.

System Enhancements

Attracting Resources

2010 was a positive year for grants. Following our successful $900,000 Substance Abuse and Mental Health Services Administration (SAMHSA) grant in 2009 for the implementation of treatment services targeted to transition age youth, MHCADSD attracted an additional $3.24 million in grant awards for treating chemical dependency, including nicotine dependence, in 2010. These grants include three multi-year federal awards from SAMHSA, and an 18 month award from Seattle King County Public Health (SKCPH).

The King County Assertive Adolescent and Family Treatment Project is expanding a county wide, multi-year effort to implement evidence-based practices throughout the county substance abuse provider network. King County is partnering with Center for Human Services to implement the Adolescent Community Reinforcement Approach (A-CRA) coupled with Assertive Continuing Care (ACC) with youth age 12-17, their families, and where appropriate, significant others, mentors or other appropriate adults. This project is supported with a SAMHSA award for $300,000/year for three years, totaling $900,000.

The King County Juvenile Drug Court Enhancement Project (JDCEP) is implementing evidence based practices throughout the MHCADSD contracted adolescent substance abuse provider network. JDCEP is implementing the A-CRA, the ACC, and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) with Juvenile Drug Court youth ages 12-17. King County is partnering with King County Superior Court, Juvenile Drug Court to enhance the treatment provided to youth in drug court. This project is supported with a SAMHSA award for $325,000/year for three years, totaling $975,000.

The King County Recovery Oriented System of Care (ROSC) for Pregnant and Parenting Women (PPW) is using the evidence-based practice, the *Community Reinforcement Approach* (CRA) as the foundation for creating a ROSC for this target population. King County is partnering with PPW substance abuse treatment specialists - *Perinatal Treatment Services, Community Psychiatric Clinic and the Parent-Child Assistance Program at the University of Washington*. The project is using the *Global Appraisal of Individual Needs* (GAIN) as the comprehensive assessment tool and implementing CRA with pregnant or parenting

women, their families, significant others, peers and other supportive people in their lives as needed. This project is supported with a SAMHSA award for $400,000/year for three years, totaling $1.2 million.

The ***Communities Putting Prevention to Work Tobacco Grant*** is providing MHCADSD capacity to incorporate tobacco treatment at all King County-funded chemical dependency and mental health treatment providers and to require tobacco- free campuses by January 1, 2012. MHCADSD is providing training, technical assistance, carbon monoxide detectors, and nicotine substitution treatment. This project is supported by an SKCPH award for $167,000 for 18 months.

Attracting these awards and bringing these evidence-based approaches to our service system is consistent with multiple King County strategic plan goals, including those related to justice and safety, health and human potential, service excellence, financial stewardship, and public engagement.

Reclaiming Futures Brings Evidence-Based Practice to the Juvenile Justice System

Reclaiming Futures is a Robert Wood Johnson Foundation initiative that helps young people in trouble with drugs, alcohol, and crime. This six-step model unites juvenile courts, probation, treatment, and the community to reclaim youth. Seattle-King County Reclaiming Futures is one of the 10 original sites (now 29) nationally selected by the Robert Wood Johnson Foundation to participate. The initiative builds upon current juvenile justice reforms and success to develop a comprehensive model of care targeting substance abusing youthful offenders and their families to provide "more treatment, better treatment and beyond treatment." Utilizing the model, MHCADSD has implemented routine standardized screening and assessment followed by coordinated care that includes increased use of evidence-based interventions within the substance abuse treatment network. This initiative has helped MHCADSD make great strides in working with non-traditional partners to go "beyond treatment." This included providing mentoring and other pro-social activities that replace crime and substance behaviors and reinforce positive behaviors. The focus for 2011 will be on strategies to further engage community meaningfully around our youth and families.

This approach to juvenile justice is consistent with King County strategic plan goals related to justice and safety as well as health and human potential.

Creating a Recovery Oriented System of Care (ROSC)

As a system of care for low income and indigent individuals, King County MHCADSD was committed to the implementation of evidence-based practices, recovery support services and the development of a ROSC in 2010. The intent of the ROSC is

to create a system where individuals, families, and communities can gain access to recovery-focused support that will increase treatment success, promote early re-engagement for those who have relapsed or who find themselves at risk of relapse, and provide pathways to recovery for individuals not in need of clinical treatment services. Such a system recognizes that recovery is a life-long journey and will provide ongoing or intermittent recovery-based services as needed throughout the lifespan of an individual.

In anticipation of Health Care reform, MHCADSD has taken initial steps in preparation of building a system comprised of networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and their families. The system includes voices of individuals in recovery and links to the faith-based community. King County staff has begun dialogue with local faith leaders to this end. The Access to Recovery 3 (ATR) project development played a key role in furthering the ROSC transformation by promoting entry or retention in recovery based, peer supported housing models that are anchored in the community. This strengthened services for people in recovery outside the traditional treatment community. The SAMHSA grant to develop a ROSC targeting pregnant and parenting women brings this transformation initiative to a high need, high priority service population.

Development of a ROSC supports the King County Strategic Plan goals in the area of Health and Human Potential by providing communities, individuals and families impacted by substance abuse or mental illness the opportunity to realize their full potential through delivery of services that are responsive to the community and encourage an active role in the recovery process.

Prevention Redesign Targets School Communities Led by Local Voices

In 2010, WA State Division of Behavioral Health and Recovery (DBHR) initiated a redesign of the substance abuse prevention system statewide. DBHR directly funds prevention in counties and the Office of Superintendent of Public Instruction (OSPI) through the federal Substance Abuse Prevention and Treatment block grant allocation to WA State. The initial redesign development partnership included counties and OSPI. As the process unfolded, the collaboration grew to include community mobilization, educational service districts, and school districts. Additionally, local partnerships were formed in order to develop the process within each county. 2010 was dedicated to planning and preparation for implementation of the model.

The redesigned system focuses all services on a geographically defined area around a school. The defined community must be small enough to truly affect and to be able to demonstrate measurable change. The state requires that the defined community include a coalition that has a focus on preventing substance use/abuse in children and youth; the coalition may focus on additional health and wellness issues as well. The coalition must include the local school; that local school will be assigned prevention/intervention staff by the educational service district. The coalition membership will include the school principal and/or the prevention/intervention staff, as well as a mix of other major sectors of community life (healthcare professionals; civic/volunteer organizations; religious/fraternal organizations; business; media; youth-serving organizations; substance abuse and mental health organizations; law enforcement; youth under 18; and parents).

Community selection is based on local data demonstrating need, and a defined commitment to work collaboratively toward preventing youth substance abuse. Based on the strategic plan developed by that community coalition from local data and self-defined need, the coalition will choose services to be delivered within the community at a variety of locations. Services will include environmental strategies, such as public awareness campaigns focused on children, youth, parents, and other community members. Capacity-building strategies will also be funded that may include training, coalition development, and sustainability of services.

The prevention redesign elements are slated to begin July 1, 2011 and King County will implement and fund the change in service model at that time. The prevention redesign supports the King County strategic plan public engagement goal to promote robust public engagement that informs, involves, and empowers people and communities.

Collaborative School-Based Mental Health and Substance Abuse Services Initiated at 21 Middle and Junior High Schools

King County held a competitive bidding process in early 2010 for the Mental Illness and Drug Dependency (MIDD) Strategy 4c, Collaborative School-based Mental Health (MH) and Substance Abuse (SA) Services. In April 2010, MHCADSD announced awards for 10 providers to deliver 13 different projects at schools throughout King County. These awards include four projects in Central King County/Seattle, three in East King County, one in North King County, and five in South King County. Services are focused on middle school-aged or junior high school-aged students in 21 schools from 11 school districts: Auburn, Highline,

Issaquah, Kent, Northshore, Renton, Riverview, Seattle, Skykomish, Snoqualmie and Tukwila.

The strategy invests in MH and SA services with a focus on selective and indicated prevention, early intervention, screening, brief intervention, and referral to treatment. While the scope of school-based MH and SA is broad and inclusive of a number of approaches, it is designed to invest resources in preventative direct services for youth. The services align with school-wide policies and address the continuum of need from primary prevention through recovery, moving beyond more traditional disciplinary responses.

Program providers focused on start-up activities including hiring staff, training staff, and working with schools to begin services for the 2010-2011 school year. These providers participated in evidence-based trainings (Life Skills Training Program and Motivational Interviewing Training). Collaborations also began with the Youth Suicide Prevention Program (YSPP) with Collaborative Service project staff attending the Applied Suicide Intervention Skills Training (ASIST). The chart below shows participating treatment agencies, districts and schools:

Organization Name	**School District (SD)/ Geographic Area**	**# of Schools**	**Schools - Junior High (JH) and Middle School (MS)**
Auburn Youth Resources	Auburn SD/ Southeast King County	4	Cascade MS, Mt. Baker MS, Olympic MS, Rainier MS
Center for Human Services	Northshore SD/ North King County	1	Kenmore JH
Friends of Youth	Issaquah SD/ East King County	2	Beaver Lake MS, Maywood MS
	Riverview and Snoqualmie SD/ East King County	2	Tolt MS in Riverview SD, Twin Falls MS in Snoqualmie SD
Kent Youth & Family Services	Kent SD/ Southeast King County	1	Mill Creek MS
Neighborcare Health	Seattle SD/ Northwest Seattle/ Central King County	1	Hamilton International MS
	Seattle SD/ Central Seattle/ Central King County	1	Secondary Bilingual Orientation Center (SBOC)
Northshore Youth & Family Services	Skykomish SD/ East King County	1	Skykomish School
Puget Sound Educational Service	Renton SD/ South King County	3	Dimmitt MS, Nelsen MS, McKnight MS

Organization Name	School District (SD)/ Geographic Area	# of Schools	Schools - Junior High (JH) and Middle School (MS)
District	Tukwila SD/ South King County	1	Showalter MS
Ruth Dykeman Childrens Center	Highline SD/ Southwest King County	2	Sylvester MS, Cascade MS
Seattle Children's Hospital, Division of Adolescent Medicine	Seattle SD/ Northeast Seattle	1	Eckstein MS
Therapeutic Health Services (THS)	Seattle SD/ Central Seattle/ Central King County	1	Madrona K-8 School

This multi-pronged collaboration meets King County Strategic plan objectives of empowering people to play an active role in shaping their future, supporting the optimal growth and development of children and youth, ensuring a network of integrated and effective health and human services is available to people in need and increasing the number of healthy years that residents live.

Access to Recovery (ATR) Provides a Pathway to Recovery-Based Housing

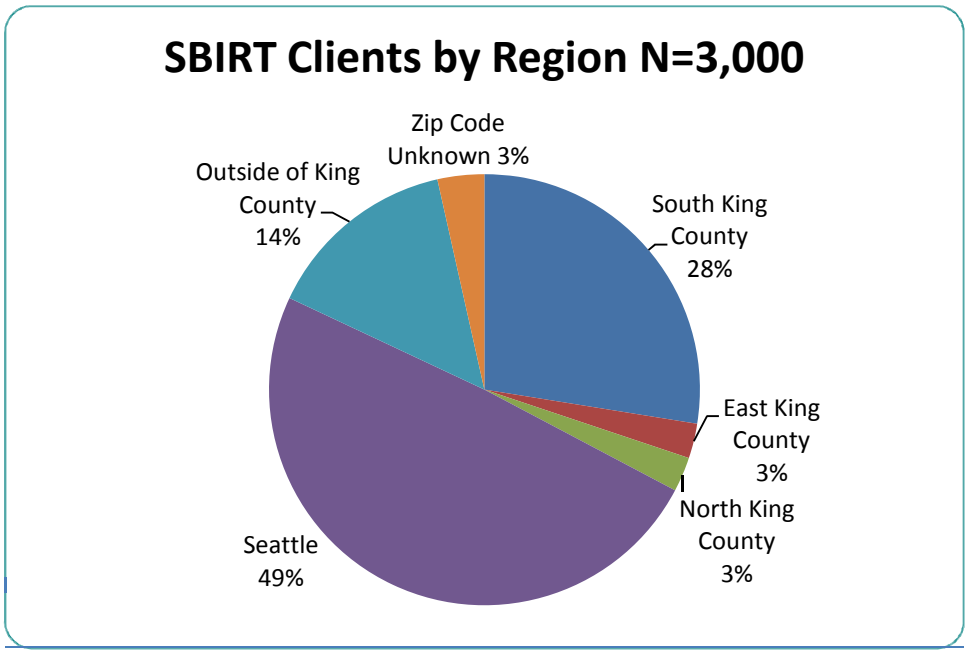
Access to Recovery (ATR) is a federally-funded grant for recovery support in its third four-year cycle. To further develop the local recovery-oriented system of care, King County is focusing ATR on recovery-based housing and other recovery support services for adults with a substance use disorder. Housing programs must be geared to recovery and include expectations for self-management and peer recovery supports. Active treatment participation with a county funded outpatient provider is not a requirement. The program will serve 278 adults in the first year.

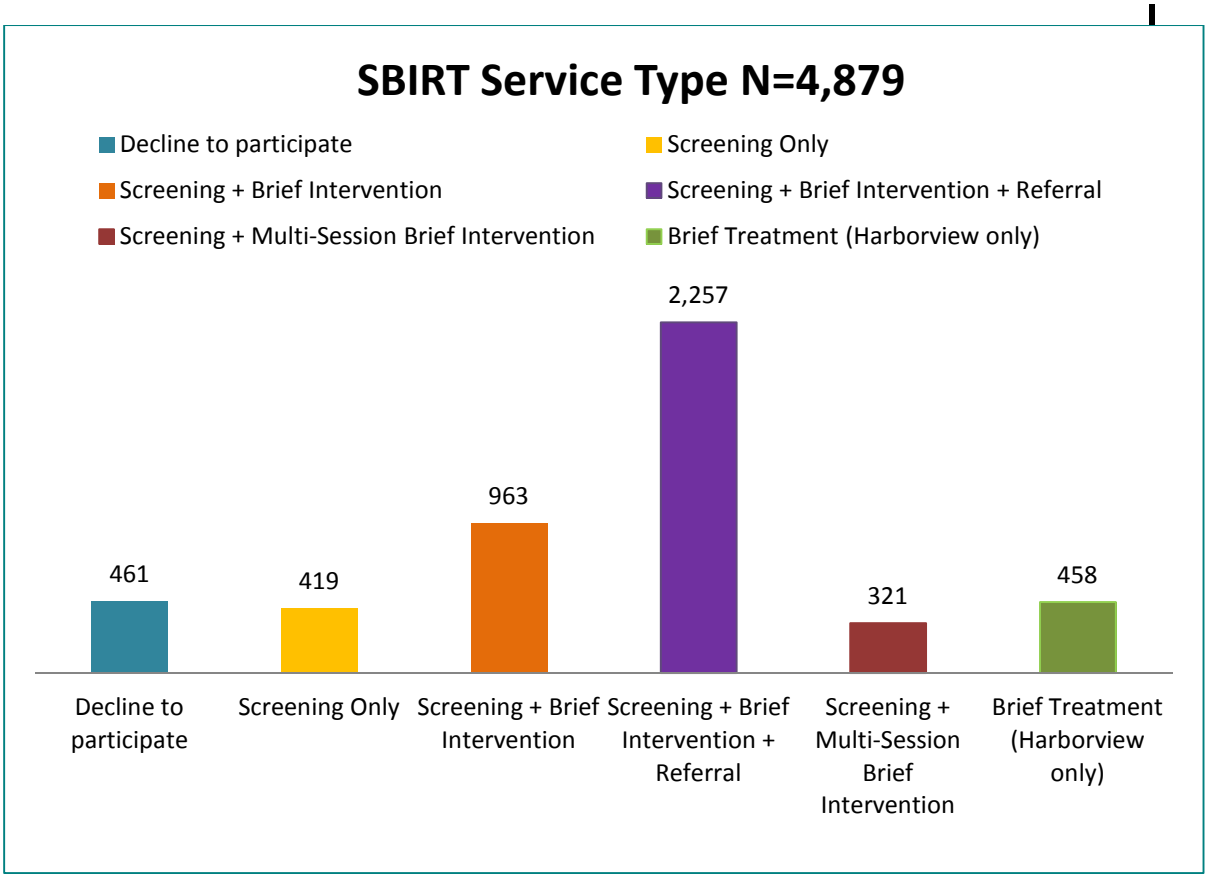
This program falls under the King County Strategic Plan Health and Human Potential Goal, Objective Four: Ensure a network of integrated and effective health and human services is available to people in need.

Screening, Brief Intervention, Referral to Treatment (SBIRT) Brings Early Intervention to Thousands

Using dollars from the county 1/10 of one percent MIDD sales tax, King County contracts for SBIRT services in three hospital emergency departments (St. Francis, Highline, and Harborview). **SBIRT** is an evidence-based practice for identifying problematic alcohol or other drug use and providing early intervention within medical settings. During 2010, 3,410 individuals received over 4,000 **SBIRT**

services. The charts below show the regional distribution of people receiving these services and the types of services provided.





This program falls under King County Strategic Plan Health and Human Potential Goal, Objective One: Increase the number of healthy years that residents live and Objective Four: Ensure a network of integrated and effective health and human services is available to people in need.

Communities Putting Prevention to Work (CPPW) Tobacco Initiative

In 2010, MHCADSD received 18 month funding from the Seattle King County Department of Public Health for a system wide anti-tobacco initiative. One of the first activities undertaken was an all-provider tobacco survey. The survey was designed to establish a baseline of provider receptivity to tobacco-free policies and readiness to integrate tobacco cessation interventions into existing services. Its intent was to gather provider attitudes around addressing tobacco use in treatment and identify barriers and needs of the provider network regarding implementing tobacco cessation. Responses were obtained from 582 people. Overall, the consensus among respondents was that providers agree with the need to address tobacco use with clients and promote tobacco-free campuses; 43 percent of respondents indicated their workplaces were already smoke-free. Feedback suggests that providers would appreciate training and easy access to resources for clients. Youth providers especially requested more training on tobacco prevention. The biggest barriers identified were heavy workloads, lack of reimbursement for treatment/lack of resources, and provider perception that clients don't want to quit using tobacco.

In collaboration with MHCADSD, SKCPH provided monthly tobacco trainings to providers, as well as one training for MHCADSD Mental Health Voices of Recovery (VOR) participants and two trainings for MHCADSD contract monitor staff.

This program falls under King County Strategic Plan Health and Human Potential Goal, Objective One: Increase the number of healthy years that residents live.

Chemical Dependency Professional Education and Training

This MIDD-funded workforce development program addresses two of the policy goals stated in the ordinance that authorized the 1/10 of one percent County MIDD sales tax:

- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

- A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

In 2010, the majority of the funding from this MIDD strategy was utilized to reimburse Chemical Dependency Professional Trainees (CDPTs) for books and

tuition toward their CDP certificates. This opportunity flooded the agencies with many more CDPTs to supervise than anticipated; this resulted in agencies requesting help with a Clinical Supervision model and with a reimbursement mechanism that assure capacity to meet state supervision requirements.

In collaboration with contracted agencies, a Workforce Development Plan for ongoing training, skill-development, and clinical supervision for Chemical Dependency Professionals was completed during 2010.

The 2011 training plan includes:

Introductory and advanced trainings for up to 75 individuals in an observational model of Clinical Supervision. In addition, five selected applicants are participating in a nine month Clinical Supervision Learning Collaborative. This process facilitates the implementation of the Clinical Supervision model at each participating agency. Each agency is required to have a change team to assure adoption of the model. This Learning Collaborative will provide recommendations to MHCADSD regarding a Clinical Supervision model and a potential reimbursement modality.

Introductory and Advanced Motivational Interviewing (MI) training for up to 75 individuals. An MI Learning Collaborative Application will be developed by summer 2011.

The MHCADSD Science to Service program connected to this MIDD strategy accomplished the following in 2010:

- Provided Nine Global Appraisal of Individual Needs (GAIN-I) assessment trainings
- Maintained a minimum of 105 certified GAIN-I site interviewers at any given time
- Provided certification and on-going quality assurance to agencies to assure reliability and validity of clinical reports and overall data
- Provided training and fidelity support for the Seven Challenges model for five agencies that participate in direct observation and support calls

This program meets King County strategic plan objectives of developing a quality work force and of providing opportunities for communities and individuals to reach their full potential.

PRIME Harnesses Technology to Create Ability to Schedule Intake Appointments with Treatment Partners in Real Time

"Provider Referral Information Management Environment" (PRIME) is a web-based behavioral health screening and referral system developed to make communication between the referring entity and the treatment agency as streamlined as possible. Referrals to a participating treatment provider are scheduled in real-time using a shared electronic calendaring system and data from a standardized screening (GAIN-SS). Scheduling in real time can be particularly important when working with youth who may be homeless or drifting from place to place. By simplifying scheduling of an assessment appointment with a treatment agency and eliminating unnecessary and unproductive voicemails, e-mails, faxes, texts, etc. treatment can begin sooner with fewer missed appointments. The goals of the PRIME system are to:

- Implement a web-based version of the Global Appraisal of Individual Needs—Short Screener (GAIN-SS) as a screening tool, with automated scoring and reporting;
- Share appropriate information about the screening
- Gather information to ensure ongoing improvement of the referral and treatment systems, and
- Increase the success rate of connecting youth to treatment

The system was tested with the King County Department of Adult and Juvenile Detention; the King County Mental Health, Chemical Abuse and Dependency Services Division; and 20 additional users/providers/accounts/ locations. The next round of improvements is planned for 2011 and will include offering the use of the PRIME System with school-based prevention and intervention programs and other programs that typically make referrals to drug treatment.

This program is consistent with the King County Strategic Plan goal of service excellence.

Chemical Abuse and Dependency Programs

Preventing and treating drug abuse and dependency is consistent with the King County Strategic Plan health and human potential goal of providing opportunities for all communities and individuals to realize their full potential, and fulfills all the strategic plan objectives allied with this goal.

Prevention

MHCADSD work with substance abuse prevention is most closely aligned with the strategic plan health and human potential objective of supporting the optimal growth and development of children and youth. King County programs address prevention of drug and alcohol abuse through two approaches. One approach, facilitated by the Alcohol and Other Drug Prevention Program, is contracting with organizations to provide drug and alcohol prevention programs. The other approach, facilitated by the Community Organizing Program, is supporting the development of community efforts to address substance abuse and violence.

Research has shown that risk factors and protective factors affect youth involvement with substance use. It is important to focus prevention efforts on youth as the majority of individuals who become chemically dependent initiate their drug use at a young age. King County conducts a participatory planning process that includes community involvement to identify which factors to target with our programming. Because this planning process results in changes to which factors are prioritized, the factors addressed by prevention programs vary over time. Factors addressed may include:

- Favorable attitudes among youth that encourage substance use (risk factor)
- Family management problems due to inconsistent guidelines for behavior and inappropriate rewards and consequences for following and not following guidelines (risk factor)
- Warm, supportive relationships with parents, teachers, other adults and peers (bonding) who reinforce competence, expect success and support not using alcohol, tobacco or other drugs (protective factor)
- Early initiation of the problem behavior (risk factor)

This section describes the King County Community Organizing Program (KCCOP) and presents 2010 data on KCCOP activities. It also describes the Alcohol and Other Drug Prevention Program (AODPP) and presents data on AODPP programs in half-year periods.

The goal of the KCCOP is to involve every citizen of King County in the prevention of youth substance abuse and violence through community based solutions. Through a community organizing model, KCCOP works with coalitions that form to address the substance abuse or violence concerns within an identified community. Such communities are defined by the common identity or interests of their

members, such as where they live or attend school, ethnicity, sexual orientation, or particular prevention goals and strategies.

In 2010, KCCOP worked with a total of 90 community coalitions with 1,279 members, down from 120 coalitions with 1,400 members in 2009, to implement strategies for the prevention of substance abuse and violence. Sixty-two of those coalitions received KCCOP mini-grants to provide prevention strategies that engaged 5,365 youth and 2,961 adults. State cuts to this program in July 2010 resulted in a reduction of three FTE of staff effort by the last quarter of the year and a reduction in resources available to channel to the community, dramatically affecting the impact of this program. During the first half of 2010, KCCOP worked with 68 coalitions boasting 1,014 members; in the second half of the year, KCCOP was only able to work with 22 coalitions having a total membership of 265. Fifty-five mini-grants were awarded during the first half of the year, but only seven could be funded during the second half of 2010.

For AODPPs, the target populations are children, youth and parents. Programs are designed to prevent or delay first use and abuse of alcohol and other drugs by reducing risk factors and enhancing protective factors.

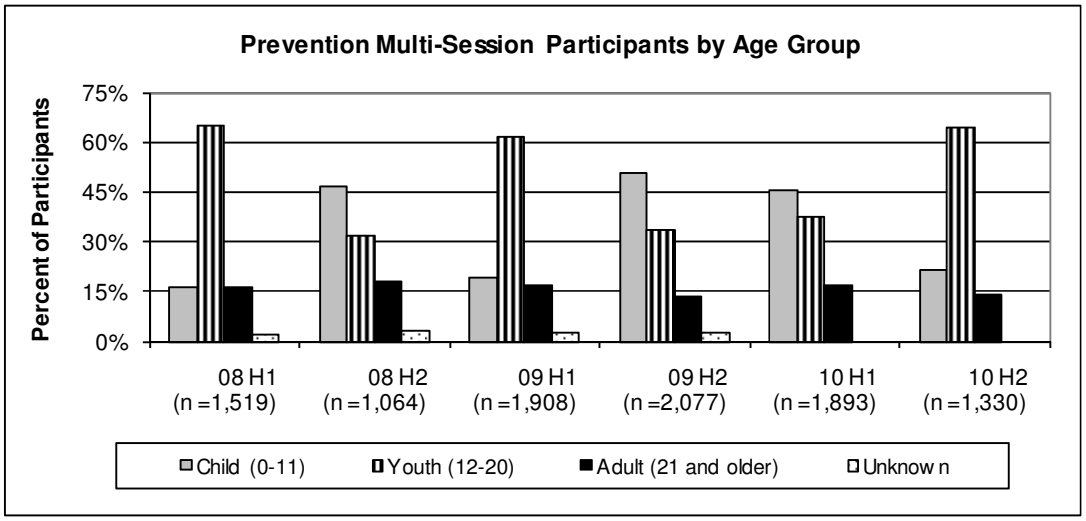
Risk and protective factors are addressed through single event or multiple session programs.

Single event programs during 2010 were:

- School/community-based events developed and sponsored by youth targeting bonding reached 21,288 youth.
- Community center activities and field trips combating favorable attitudes that encourage substance use reached 836 youth.

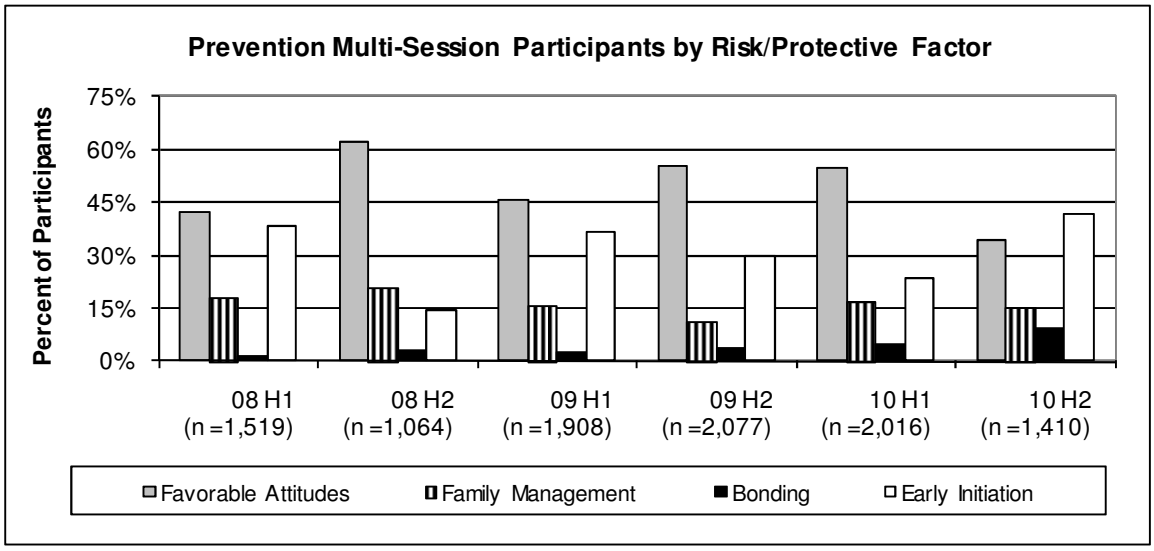
Prevention programs that have a multiple session format, such as skills training classes or support groups, collect demographic data about participants. Only multi-session programs are included in the following graphs.

The following graph shows the number of participants by biennial quarter and age group.



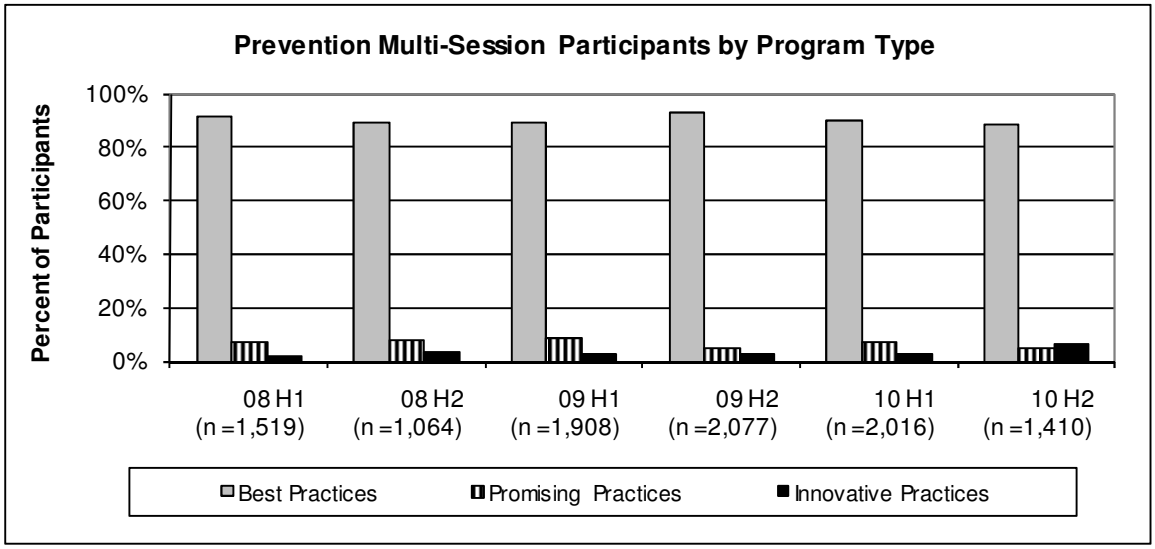
The large changes above in the relative proportions of the Child and Youth age groups reflect programs based on the school calendar as well as biennial changes in targeted risk/protective factors.

The following graph shows the number of participants by the risk or protective factor that is targeted by the program. Participants in more than one program during a quarter are counted for each one.



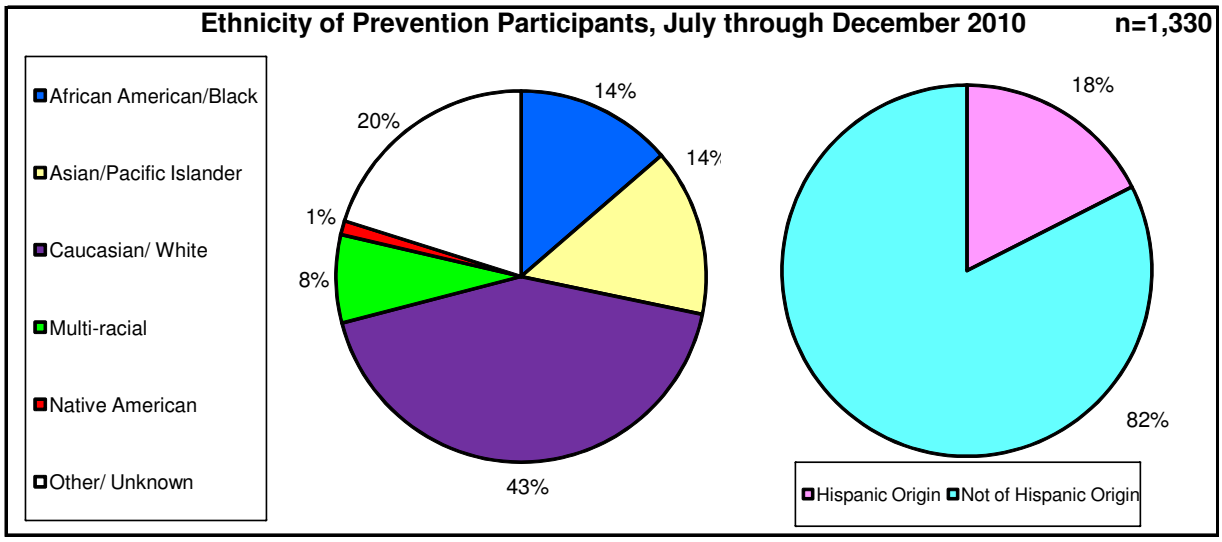
As with age groups, the changes above in the percentages of risk factors result from biennial changes in the targeted factors and the fact that many prevention programs are scheduled in conjunction with the school calendar.

Research has validated the effectiveness of some prevention programs while others have not been evaluated yet. Applying this research, programs funded in King County are categorized as "best practices," "promising practices," or "innovative practices." The following graph shows the number of participants by biennial quarter and program type. Participants in more than one program during a quarter are counted for each one.



The results above show continued focus on prevention methods that have been demonstrated to be effective. The biennial quarterly variation in participant numbers reflects programs based on the school calendar as well as differences in the mix of services during the time period.

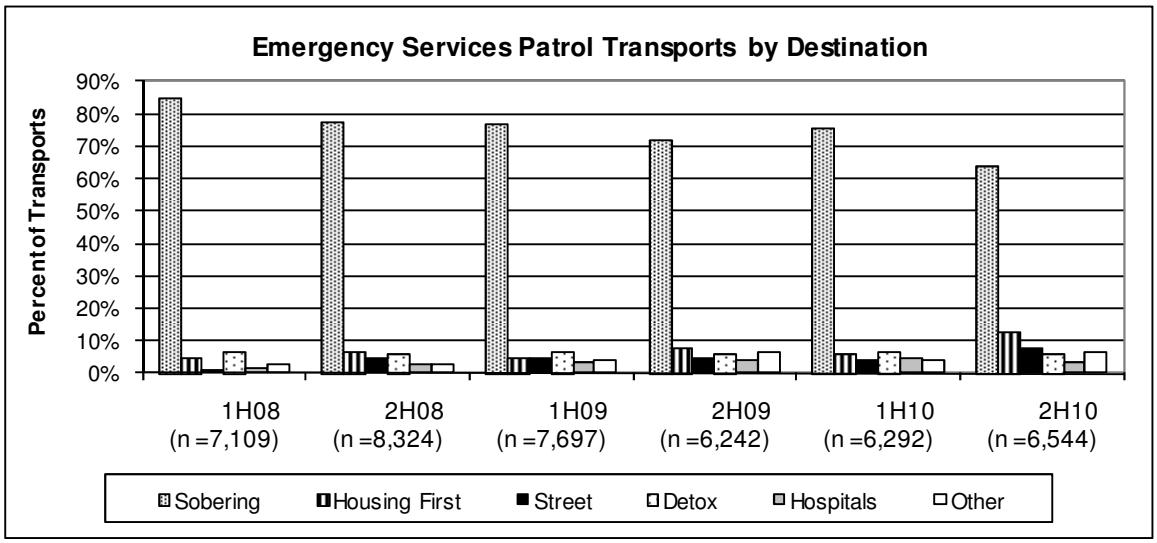
The charts below show the ethnicity of people who participated in multi-session prevention programs from July through December 2010.



Emergency Services Patrol

The main duty of the Emergency Services Patrol (ESP) screeners is to relieve fire, police, and medics from caring for chronic users. They do this primarily by transporting publicly inebriated individuals to the Dutch Shisler Service Center (DSSC) or other safe environment. The screeners also patrol the downtown core seeking out individuals in need of service. In addition, they transport clients away from sobering to other service providers. The service operates 24 hours a day, seven days a week.

The chart below shows the number of individuals transported and the destination of each transport by biennial quarter.



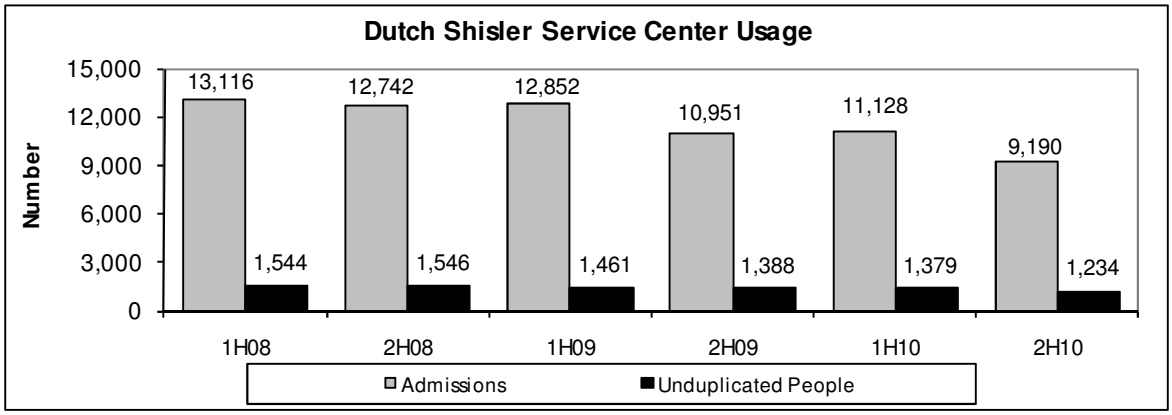
The decrease in the percentage of transports to Sobering over the quarters in this report reflects an increased focus by ESP staff on transporting people away from the neighborhood when they finish their stay, and increased programming at DSSC designed to engage clients in supportive programs that are pathways to treatment.

Client specific demographic data about ESP services are not currently available. Until those data are available, the demographic data from DSSC provide a good approximation of ESP client demographics because a majority of transports are to that site.

Dutch Shisler Service Center (DSSC)

The DSSC serves as a safe and secure place for persons to sleep off the acute effects of intoxication. It also serves as a center for clients to access case management services, outpatient chemical dependency treatment, and assistance to move towards greater self-determination.

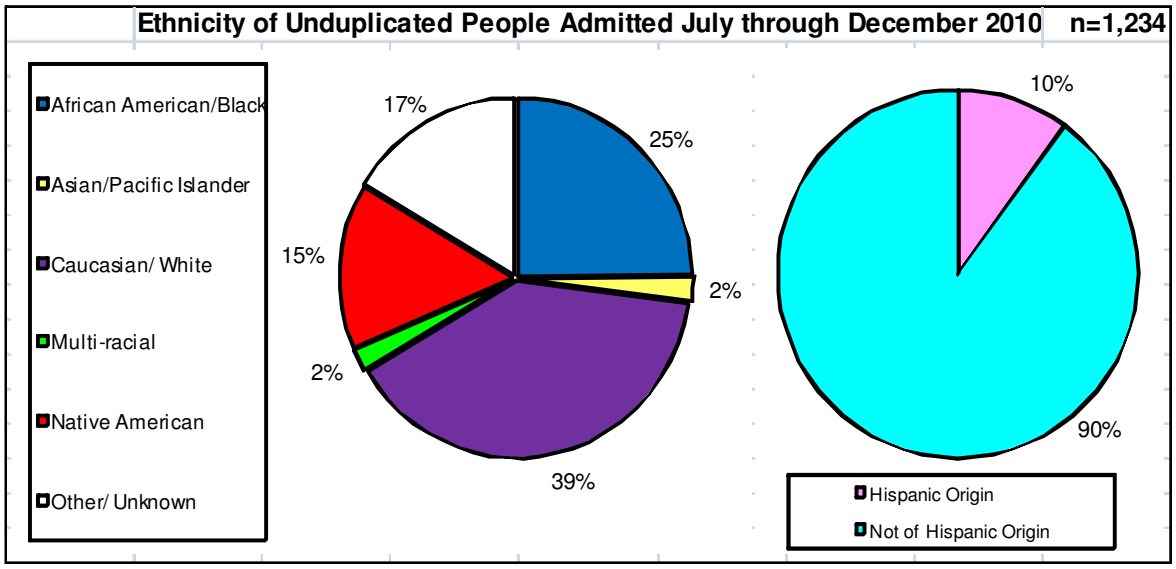
The chart below shows the number of admissions to the DSSC for sobering services, and the number of unduplicated people who used that service.



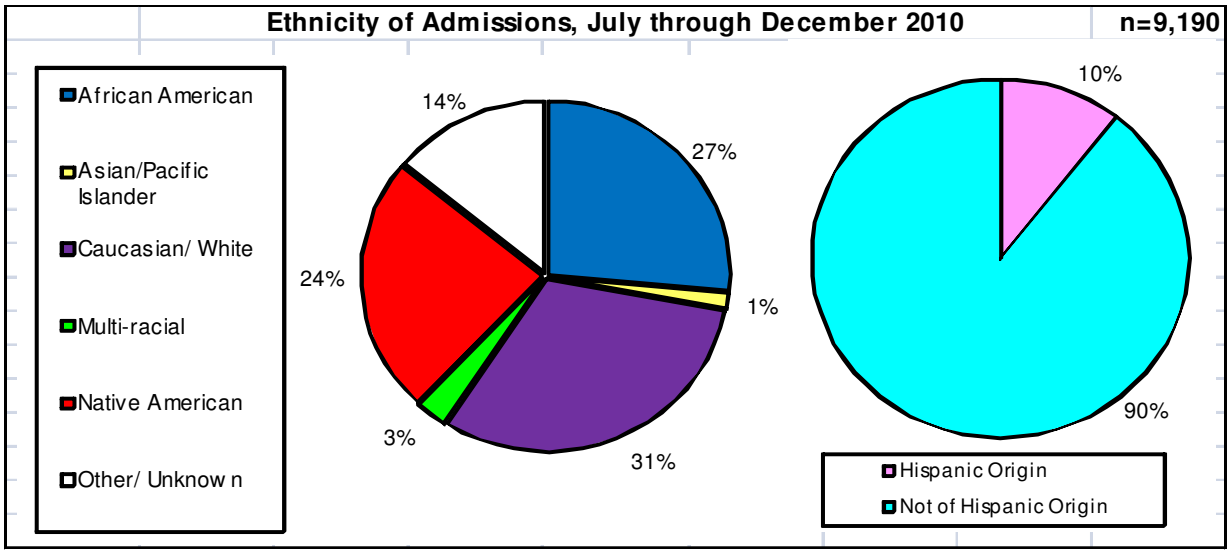
From the data above, it is clear that some individuals have multiple admissions to DSSC. In the last biennial quarter, 8.1 percent (100) of the 1,234 people admitted accounted for 55 percent of the total admissions. These 100 individuals averaged 51 admissions each during the six-month period, with a range from 25 to 152 admissions. Frequent users of the center are often involved in multiple systems, such as primary and behavioral health, social services, criminal justice, and housing. These individuals have complex and chronic needs and are generally not served effectively by the high-cost settings, such as emergency departments, they tend to access.

The decline in sobering admissions since 2008 is, in part, the result of proactive programming started in 2009 to engage frequent users in case management, supportive housing and treatment. With the program changes, client cases are staffed at a twice-monthly collaboration of service providers and local government staff that focuses on persons with chronic use disorders who appear frequently for services at hospitals, jail and the sobering center. In addition to this regular collaboration across service systems, staff at DSSC meet weekly to discuss challenging cases and to identify opportunities for clients of the center. This programming has been supported by several new Housing First projects and other "low barrier" permanent supportive housing resources, which do not require abstinence as a condition for housing. Low-barrier housing is an effective way to engage people with persistent, long-term substance abuse in services and to help them achieve stability. When individuals have their own residences, they are less likely to be on the streets, come to public attention, or require a facility where they can safely await stabilization of their intoxication.

The following charts show the ethnicity of unduplicated people served by DSSC from July through December 2010. (See Appendix A for additional details.)



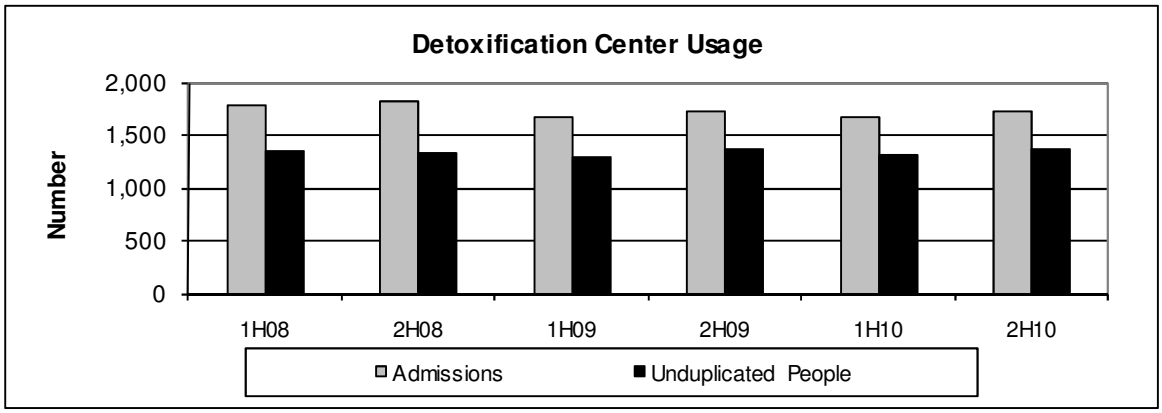
Among those admitted to DSSC during July through December 2010, the percentage who are Native American (15%) is much higher than the percentage of Native Americans in either the general population (2%) or in any other drug/alcohol program area (see Summary Data, Demographic Detail). In addition, a disproportionate number of the frequent users of DSSC are Native American: 21 percent of those admitted five times or more in the last biennial quarter were Native American. As shown in the chart on the left below, 24 percent of all admissions to DSSC in the last biennial quarter are for Native Americans although Native Americans are only 15 percent of the unduplicated individuals served, as shown in the chart on the left above.



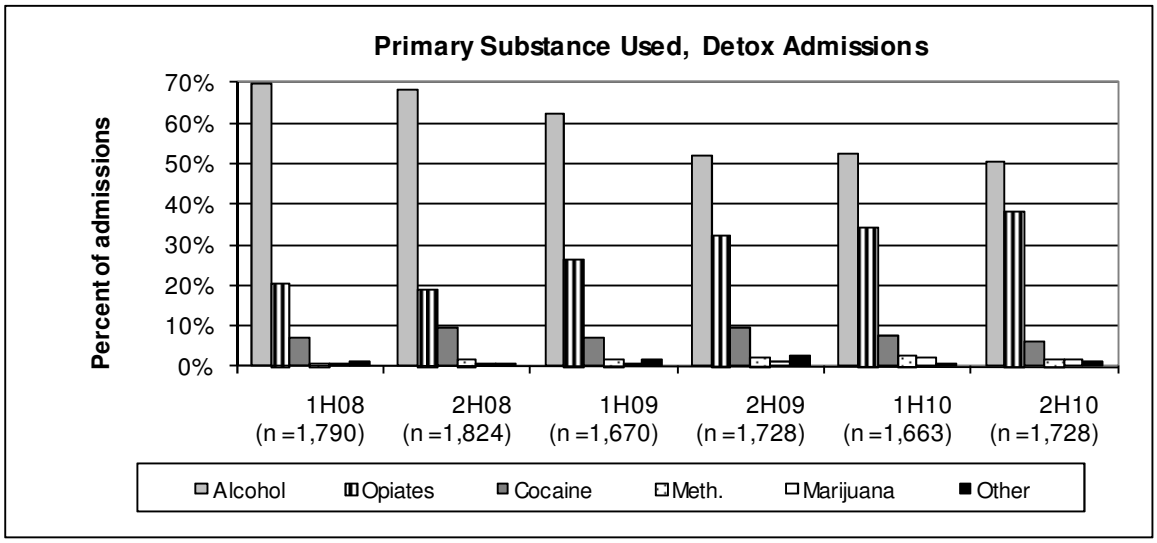
Detoxification Center

Detoxification services are provided to indigent clients who are withdrawing from alcohol or other drugs. Upon successful completion of detoxification services, clients are referred for ongoing treatment and support.

The chart below shows the number of new admissions to the Detoxification Center during each biennial quarter and the number of unduplicated people admitted.



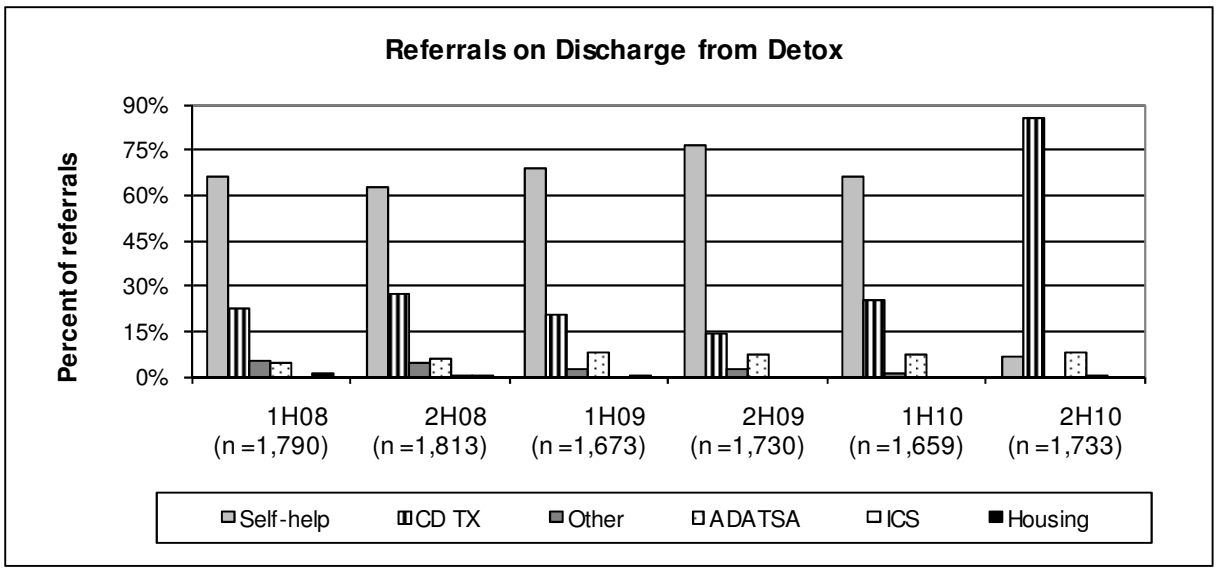
The following chart shows the primary substance used by people admitted to the Detoxification Center. This is usually, but not always, the substance for which detoxification is needed. (See Appendix A for more information.)



There has been a steady increase over the last four biennial quarters in the percentage of Detoxification clients who indicate opiates as their primary drug used. Alcohol has gone from being the primary substance used for 70 percent of admissions in 2008 to only half of admissions in the second half of 2010. From the first half of 2008 through the first half of 2010, there was also a steady increase in the number and percentage of young adults under thirty entering detoxification

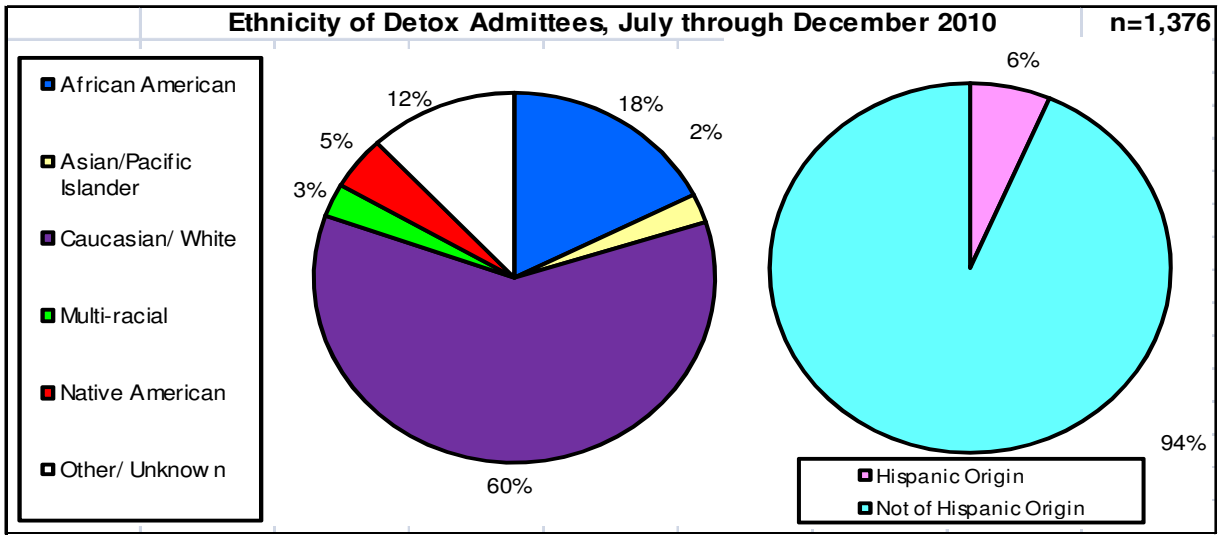
services. Among all individuals admitted from 2008 through 2010, more than 60 percent of those under 30 indicated opiates are their primary drug used compared to 22 percent of those 30 through 69. See the "Program Comparisons" section for more discussion of these changes.

The chart below shows the resources to which people were referred when discharged from the Detoxification Center, based on the biennial quarter of the discharge.



The dramatic increase in referrals to treatment in the last biennial quarter is the result of more accurate data reporting and does not indicate a change in the actual referral practices at the Detoxification Center.

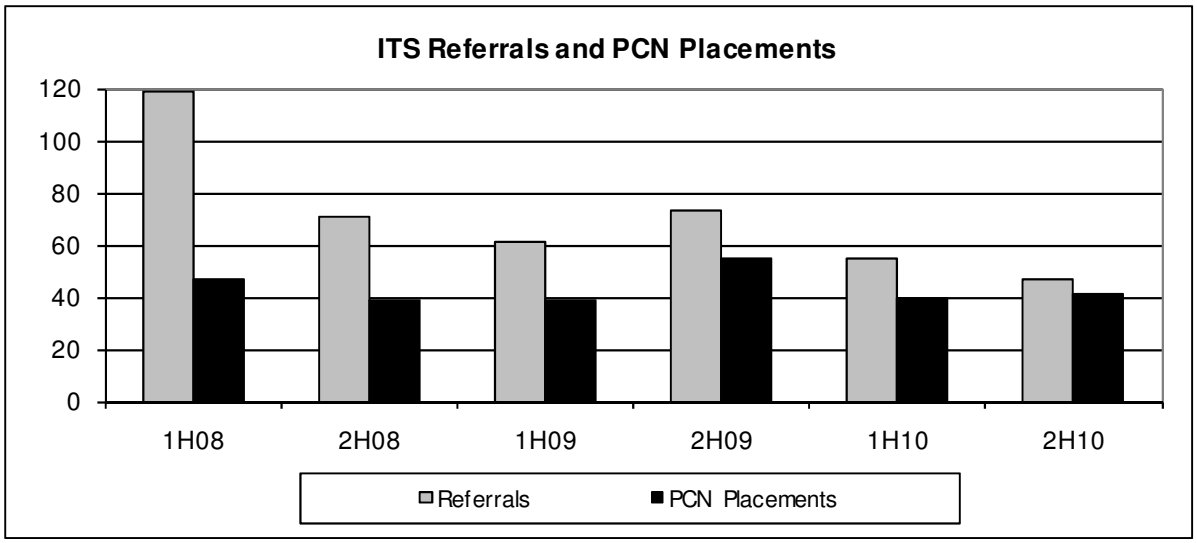
The charts below show the ethnicity of unduplicated people admitted to the Detoxification Center from July through December 2010. (See Appendix A for additional details.)



Involuntary Commitment Services

Involuntary Commitment Services (ICS) include investigation and evaluation of facts to determine whether a person is incapacitated as a result of chemical dependency. If a chemical dependency specialist determines there is reliable evidence to support a finding of incapacity, a petition for commitment can be filed on behalf of the incapacitated person. Courts can then commit a person to a locked treatment facility for intensive treatment.

The following chart shows the referrals received by ICS for investigation and the number of commitments that resulted in a placement at Pioneer Center North (PCN) for inpatient treatment.

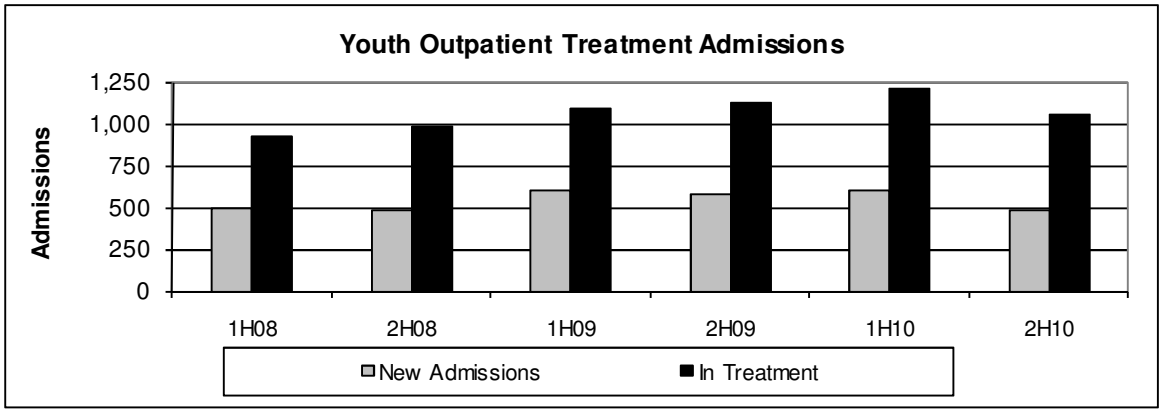


Although the number of referrals decreased substantially after the first half of 2008 when ICS staff were reduced from two to one, the number of PCN placements has remained about the same. This continued success at getting incapacitated individuals into treatment at PCN, despite reduced staff resources, is the result of focusing on gravely disabled adults who are willing to enter treatment.

Outpatient Treatment – Youth

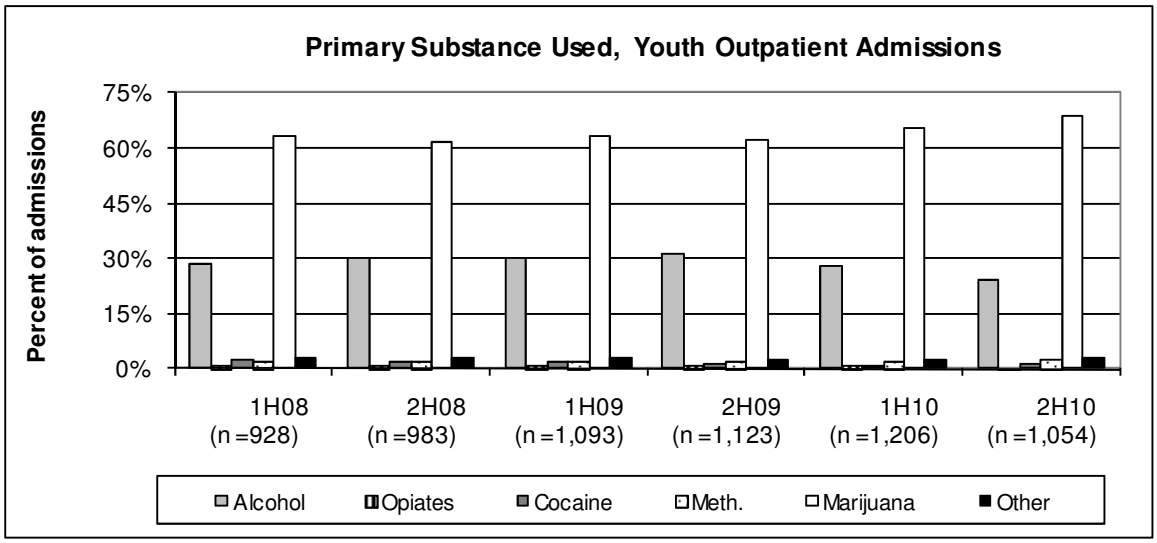
Outpatient treatment services for youth and young adults are targeted for low-income and indigent youth. Services include development of sobriety maintenance skills, family therapy or support, case management and relapse prevention. Services are expected to improve school performance and peer and family relationships, prevent or reduce criminal justice involvement, and to decrease risk factors associated with substance use and abuse.

The following chart shows existing caseloads plus new admissions to outpatient treatment for youth under 18. Both "new admissions", which started during the biennial quarter, and "in treatment", which includes youth who started treatment prior to the start of the quarter and were not yet discharged, are shown.



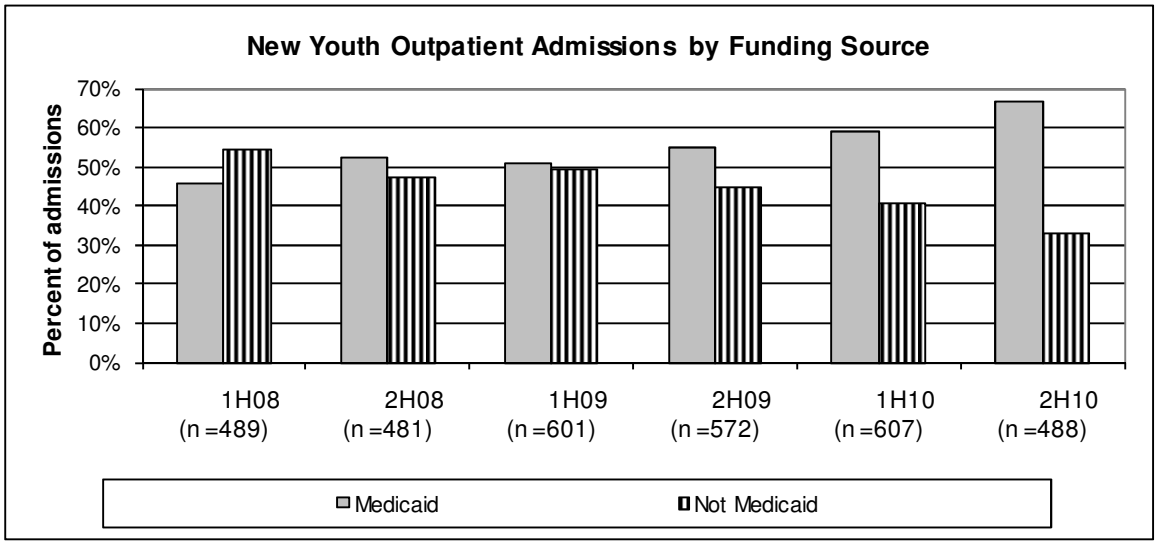
Beginning in 2007, MHCADSD joined forces with providers, schools and DBHR to implement several strategies to improve referral networks, review school drug and alcohol policies, address the shortage of qualified treatment staff, and increase vendor rates. Those efforts increased treatment accessibility and new admissions increased from 2007 through 2009. In addition to the higher level of new admissions, the number of all youth in treatment has increased steadily from the first half of 2007 through the first half of 2010 because a larger percentage of youth are remaining in treatment longer than six months. A number of studies have linked treatment retention to better treatment outcomes, so this longer retention in treatment is good news.

The following chart shows the primary substance used by youth admitted to outpatient treatment.



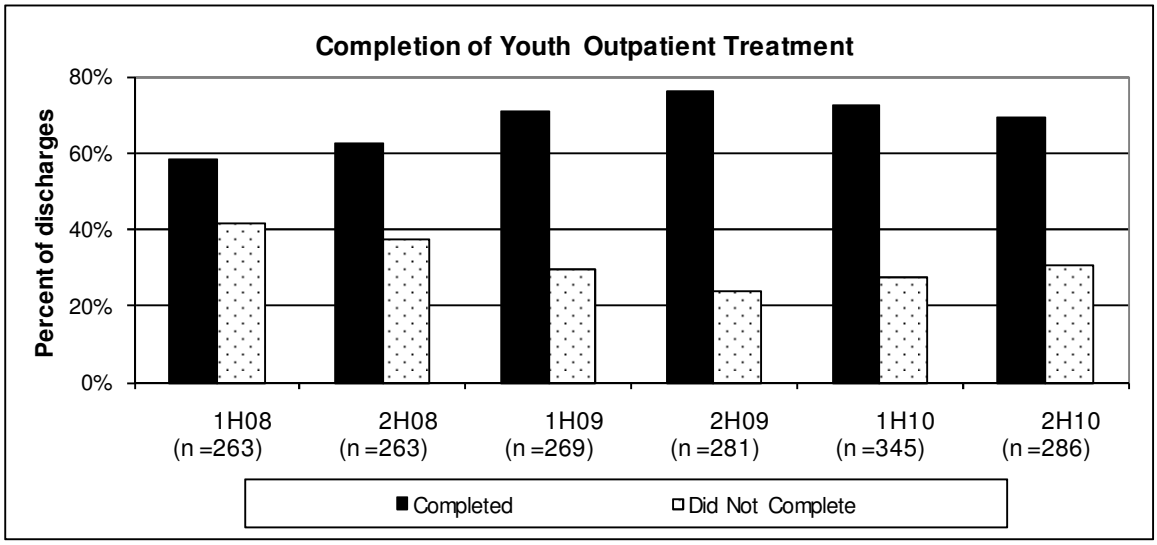
While the most frequently used drug among youth in treatment is marijuana, a significant percentage of youth are using alcohol. Very few are in treatment for opiate use, which appears to become more problematic for people in their twenties.

The chart below shows the proportion of newly admitted youth each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



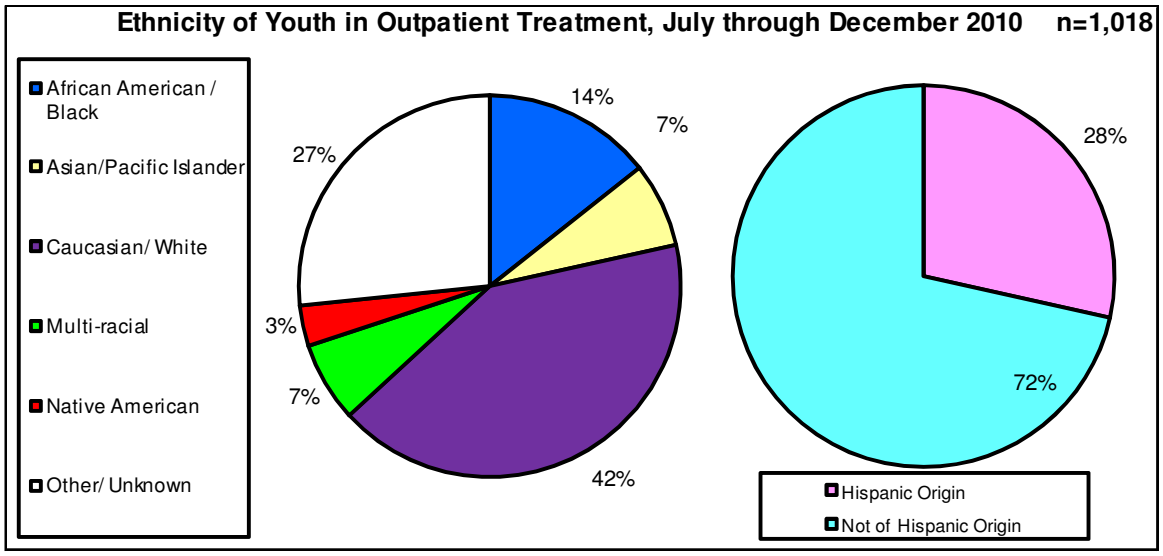
Dramatic reductions in state non-Medicaid funding for youth outpatient treatment are evident in the large increase in the percentage of Medicaid funded admissions in the second half of 2010. The number of people admitted to treatment with non-Medicaid funding declined more than 35 percent from the second half of 2009 to the second half of 2010. This was only slightly off-set by a three percent increase in the number of people with Medicaid coverage who were admitted.

The following chart shows rates for successfully completing treatment for youth who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for youth outpatient treatment for the second half of 2010 was 53 percent compared to 68 percent for King County.

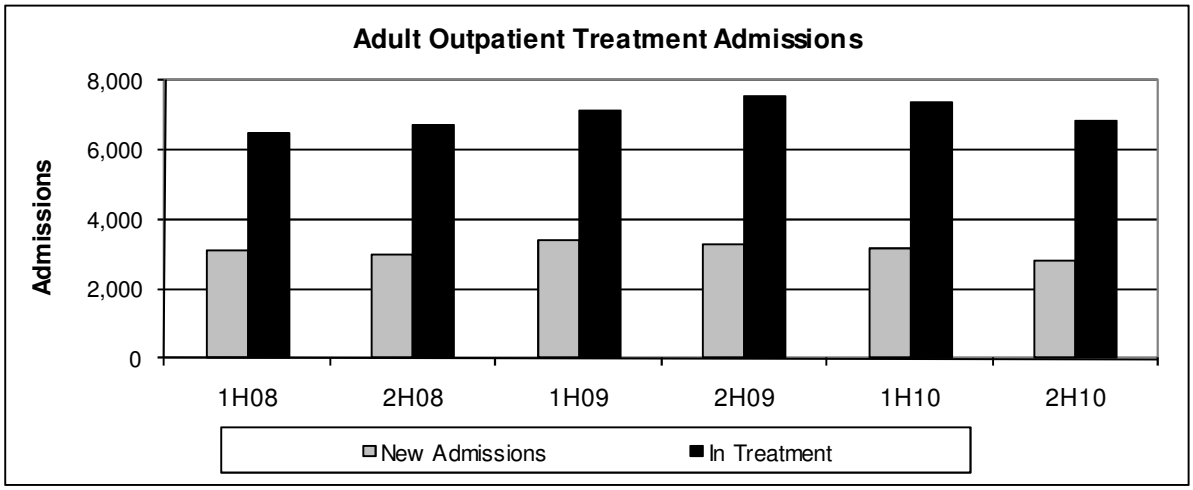
The charts below show the ethnicity of unduplicated youth receiving outpatient treatment from July through December 2010. (See Appendix A for additional details.)



Outpatient Treatment - Adult

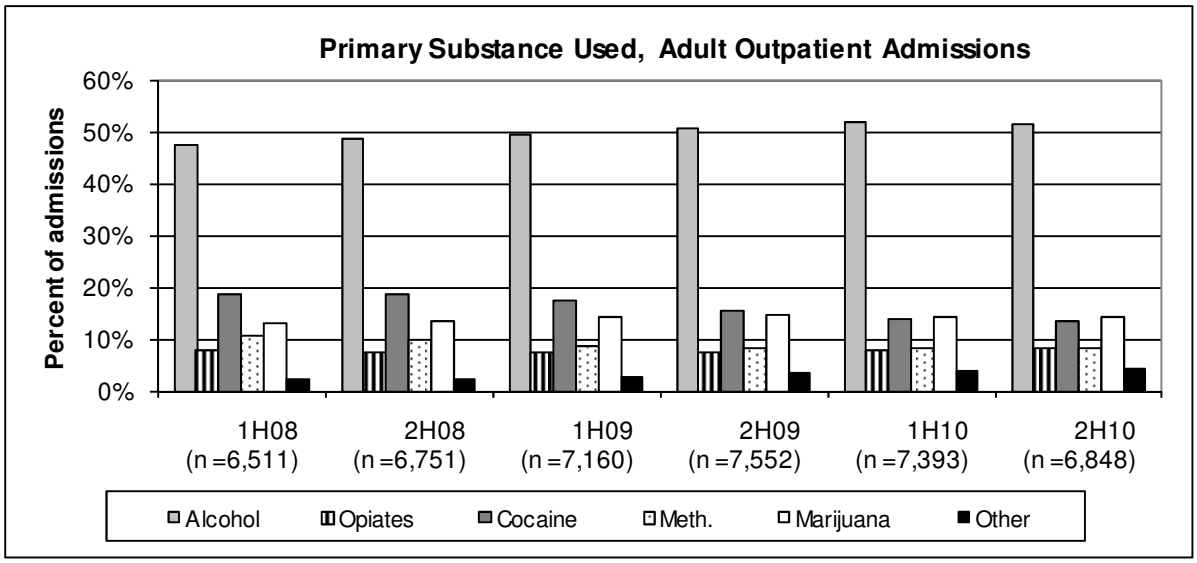
Outpatient treatment services provide treatment to low-income and indigent adults who need treatment to recover from addiction to drugs and/or alcohol. Services are designed to assist clients to achieve and maintain sobriety, and can include individual face-to-face treatment sessions, group treatment, case management, employment support, or other services, including referrals to appropriate service agencies.

The following chart shows caseloads and admissions to outpatient treatment for adults, 18 and over. Both "new admissions", which started during the biennial quarter, and "in treatment", which includes people who started treatment prior to the start of the quarter and were not yet discharged, are shown.

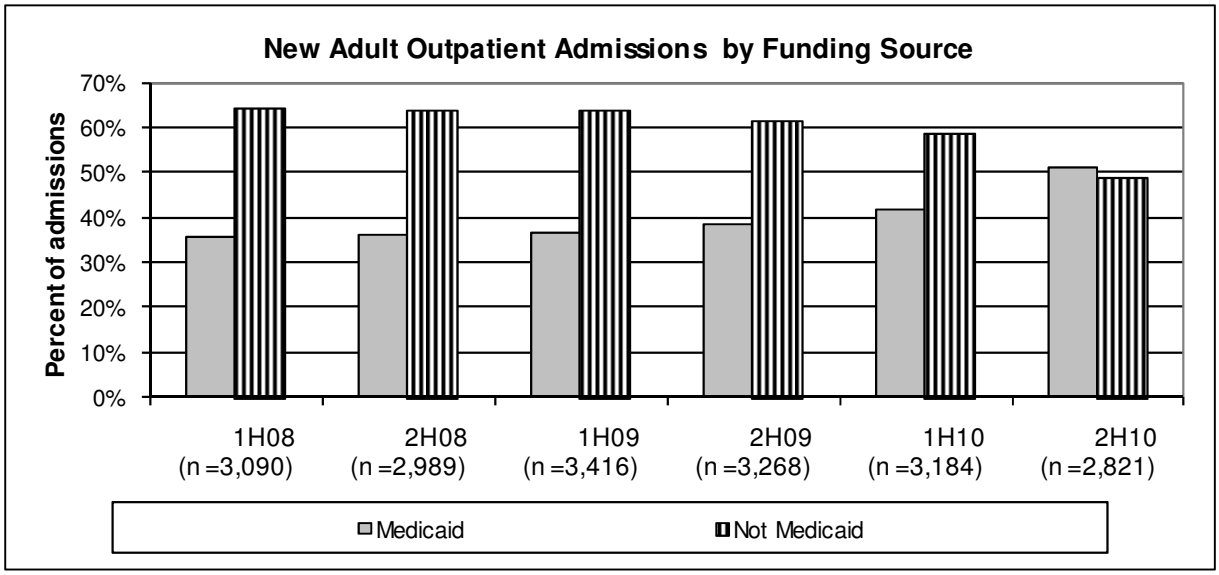


The total number of people in treatment increased from early 2006 through 2009 before declining in 2010. The increase resulted from people remaining in treatment longer, as well as an increase in new admissions that was made possible, in part, by local MIDD tax dollars that began during this time period. The longer treatment duration resulted from increased local funding to pay for treatment and to meet other needs that can interfere with engagement in treatment. Longer treatment durations also reflect growing recognition in the field of the importance of longer retention to solidify recovery, as well as the need for longer-term treatment for individuals living with both drug dependency and mental illness. The decreases from late 2009 through 2010 in the number of people starting treatment and the number remaining in treatment reflect decreased state funding available for outpatient treatment for those who do not have Medicaid coverage.

The chart below shows the primary substance used by adults admitted to outpatient treatment.

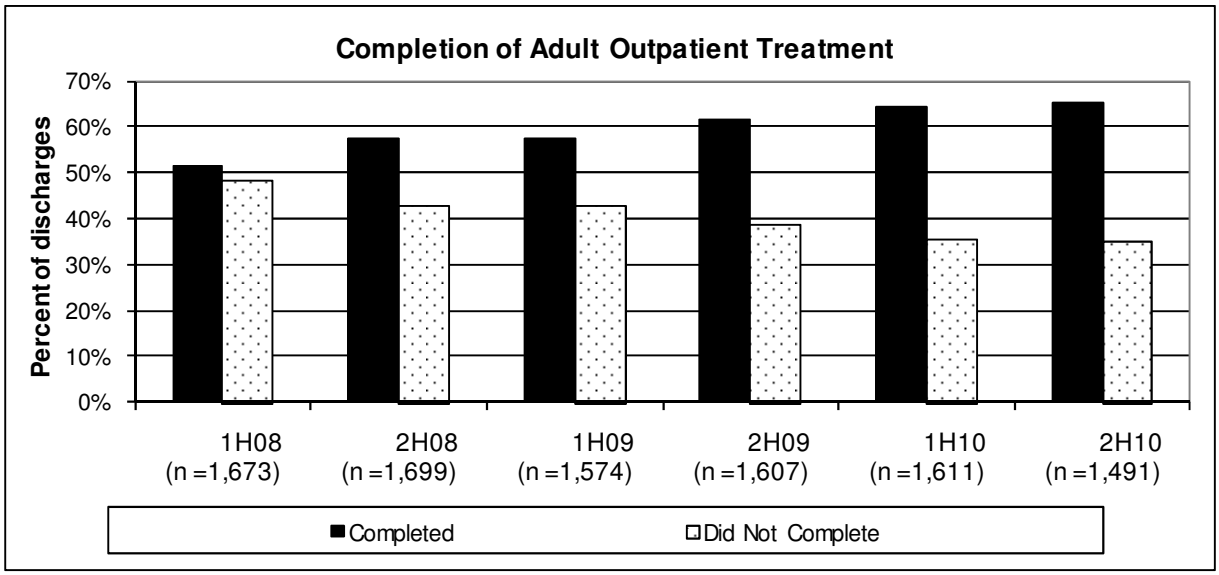


The following chart shows the proportion of newly admitted adults each biennial quarter whose treatment is funded by Medicaid vs. other public funding.



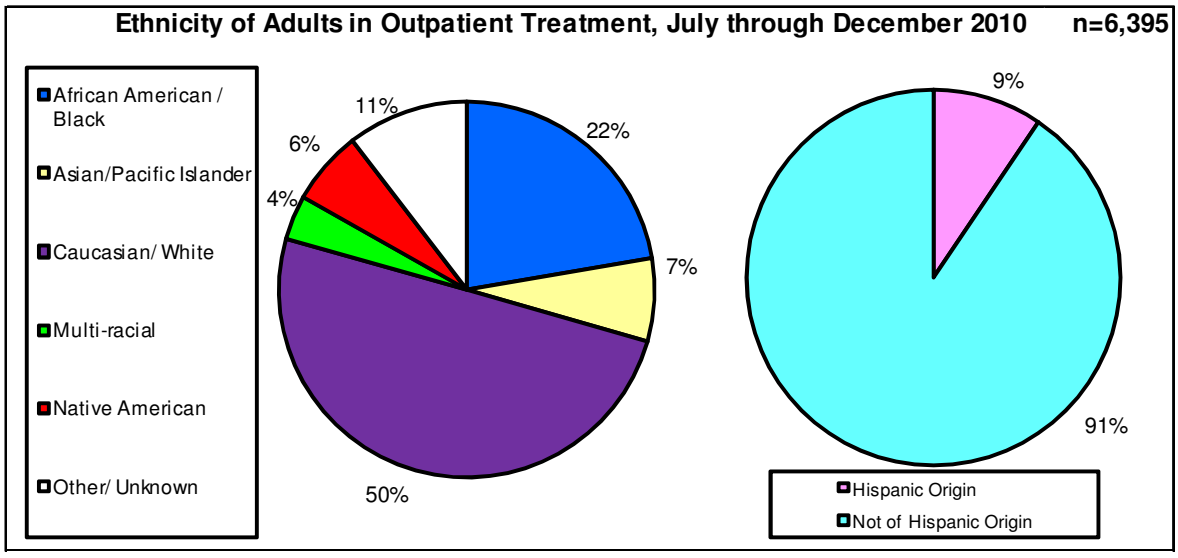
Dramatic reductions in state non-Medicaid funding for adult outpatient treatment are evident in the large increase in the percentage of Medicaid funded admissions in the second half of 2010. The number of people admitted to treatment with non-Medicaid funding declined more than 30 percent from the second half of 2009 to the second half of 2010. This was partially off-set by a 14 percent increase in the number of people with Medicaid coverage who were admitted.

The chart below shows rates for successfully completing treatment for adults who were discharged during the quarter. (See Appendix A for details on how the rate is determined.)



The statewide completion rate, excluding King County, for adult outpatient treatment for the second half of 2009 was 51 percent compared to 64 percent for King County. Treatment completion rates for adults have increased substantially over the past three years.

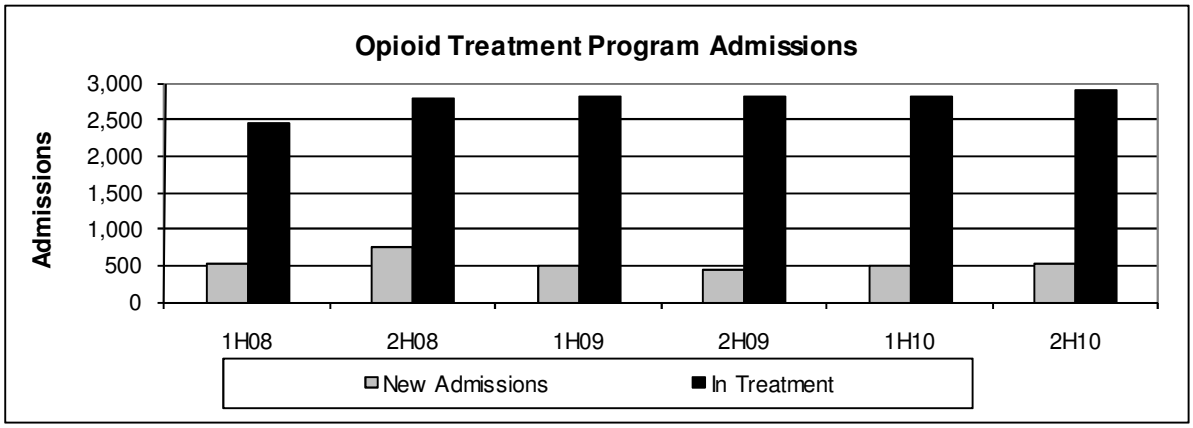
The charts below show the ethnicity of unduplicated adults receiving outpatient treatment from July through December 2010. (See Appendix A for additional details.)



Opioid Treatment Programs

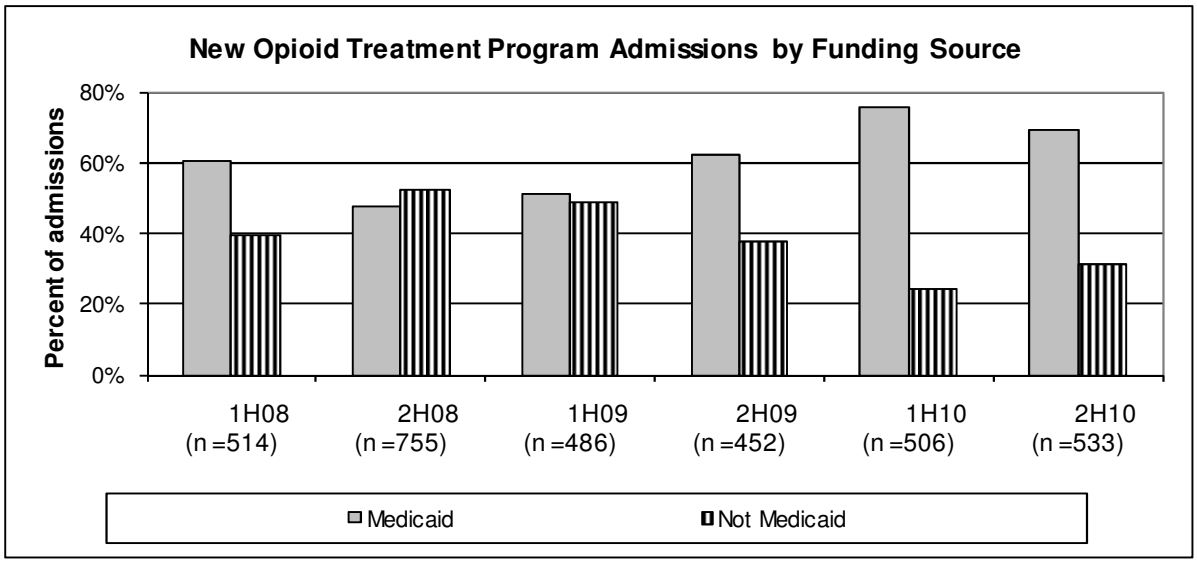
Opioid treatment programs provide medically supervised medication-assisted treatment services to persons with chronic opiate addictions, whether to heroin or prescription opiates. In addition to physical exams and medical monitoring, clinics provide individual and group counseling, medications, urinalysis screening, referral to other health and social services, and patient monitoring.

The chart below shows caseloads and admissions to opioid treatment programs. Both "new admissions", which started during the biennial quarter, and "in treatment", which includes people who started treatment prior to the start of the quarter and were not yet discharged, are shown.



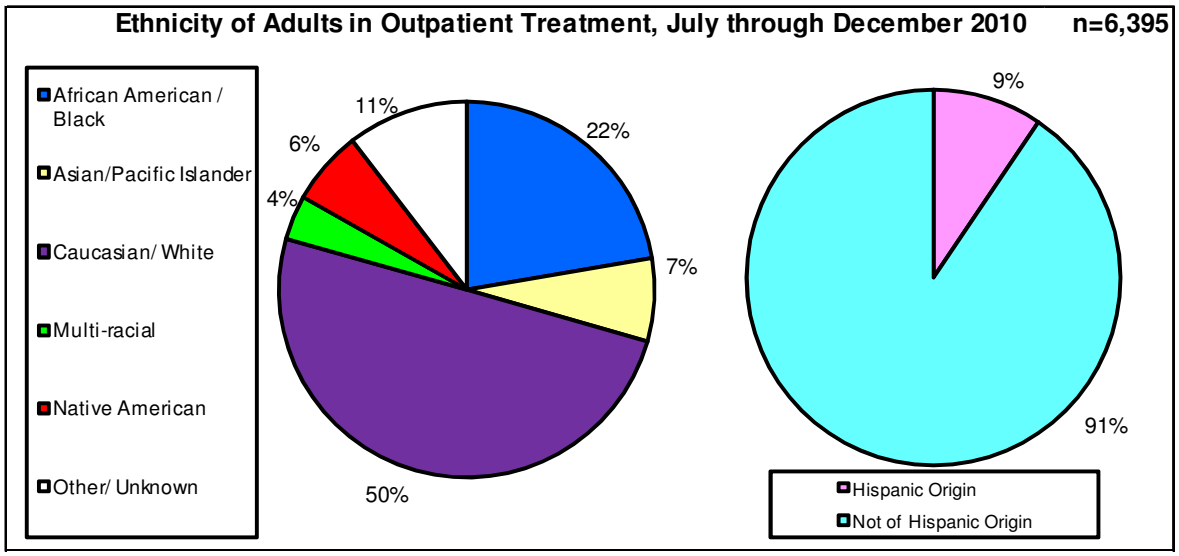
New admissions and all people in treatment both increased in the second half of 2008 as MIDD Action Plan funding from local sales tax became available. Consistent with the goals of this treatment modality, individuals tend to be retained in medication-assisted treatment for long durations, limiting the availability of new treatment slots. The waiting list to enter this type of treatment at the end of 2010 was almost 350 people.

The following chart shows the proportion of newly admitted people each biennial quarter whose opioid treatment is funded by Medicaid vs. other public funding.



The large increases during the second half of 2008 and first half of 2009 in the percentage and numbers of Not Medicaid admissions reflect MIDD funds that were directed to opioid treatment programs when MIDD funding first became available.

The following charts show unduplicated people receiving opioid treatment from July through December 2010. (See Appendix A for additional details.)



Summary Data

Overview

This section provides summary data for the current calendar year on services provided, dispositions and demographics of individuals served. It also provides summary data for the last three calendar years for financial revenues and expenditures.

The services data are for the same program areas and measures that were presented graphically in the Programs section. The time period that the data describe is different. Data in this section are for the most recent calendar year, which is the same time period as the last two biennial quarters shown in the charts. (See Appendix A for additional details.)

The demographic data are broader than the data in the Programs section. For each area where data on unduplicated individuals are available (that is, all areas except the Emergency Services Patrol), the gender, race or ethnic group and Hispanic origin status of all individuals served during the most recent calendar year are reported.

To provide context, U.S. Census Bureau data for gender and ethnicity in the youth and adult populations in King County that are below the federal poverty level are shown in addition to the demographic data for each program. Although many people with somewhat higher incomes also qualify for public funding, these data approximate the gender and ethnic mixtures among King County residents who are eligible for publicly funded services. Data for the "Youth Outpatient" programs should be compared to the "Youth" population. All other programs except Prevention serve only adults. (Data Source: U.S. Census Bureau, 2005-2009, American Community Survey, B17001A-I tables.)

The financial data (see page 43) include a financial plan for actuals for 2008, 2009, and 2010, and the expenditures for outpatient treatment services that were funded by the MIDD Action Plan. The financial plan shows the beginning fund balance, revenues received by type of revenue, expenditures made by category of expenditure, and the ending fund balance. The chart at the bottom of the page combines the contracted expenditures for outpatient treatment services from the financial plan with the MIDD expenditures, which started in October 2008. The chart is broken out by outpatient treatment services for adults and youth, and opioid treatment programs. Total contracted outpatient services accounted for $20,833,653 in 2008, $20,823,465 in 2009, and $17,021,862 in 2010.

Title XIX (Medicaid) dollars are not included in the financial plan figures. Title XIX dollars combine state and federal funds to pay for treatment services. Money is set aside from the MHCADSD biennium contract with the State and allocated to chemical dependency treatment agencies to provide treatment services. These dollars are then matched with federal dollars and disbursed by the state directly to

agencies for treatment services provided to Medicaid recipients. For 2010, the Title XIX County Summary Match Reports and agency reports as recorded in the MHCADSD Invoice Processing System show that $9,324,585 was paid to agencies for treatment services utilizing an estimated $3,729,834 in state match. This is an increase of 1.2 percent or $109,404 paid to agencies for treatment services above the amount paid in 2009, and an estimated decrease in the amount of state match of 19.1 percent or $877,757 when compared to match utilization in 2009. State match figures are estimated because the state's adoption during 2010 of a new Medicaid claims payment system resulted in some irregularities in the payment data available. The decrease in match funding needed was the result of federal stimulus reduction in the state match requirements.

Services and Dispositions, January – December 2010

	Number	Percent
Prevention Participants	2,784	100%
Age Group		
Child	1,090	39%
Youth	1,224	44%
Adult	470	17%
Unknown	0	0%
Risk/Protective Factor		
Favorable Attitudes	1,440	49%
Family Management	525	18%
Bonding	145	5%
Early Initiation	804	28%
Program Type		
Best Practices	2,626	90%
Promising Practices	197	7%
Innovative Practices	91	3%
ESP Transports		
All Destinations	12,836	100%
Sobering	8,918	69%
Housing First	1,175	9%
Street	760	6%
Detox	785	6%
Hospitals	519	4%
Other	679	5%
Sobering Center		
Admissions	20,318	
Unduplicated People	2,091	
Detoxification Center		
Admissions	3,391	
Unduplicated People	2,435	
Admissions by drug of choice	3,391	100%
Alcohol	1,748	52%
Opiates	1,229	36%
Cocaine	238	7%
Methamphetamines	77	2%
Marijuana	64	2%
Other	35	1%
Referrals on discharge, all d/c	3,393	100%
Self-help	1,214	36%
CD TX	1,902	56%
Other	17	1%
ADATSA	257	8%
ICS	3	0%
Housing	0	0%

	Number	Percent
Involuntary Commitment Services		
Referrals	102	
Unduplicated people	99	
PCN Placements	81	
Outpatient Treatment		
Youth		
New admissions	1,095	
In Treatment	1,694	
Unduplicated people (open)	1,564	
Open admissions by drug of choice		
Alcohol	442	26%
Opiates	14	1%
Cocaine	19	1%
Methamphetamines	33	2%
Marijuana	1,144	68%
Other	42	2%
New admissions by Medicaid status		
Medicaid	685	63%
Not Medicaid	410	37%
Discharges (during year)	1,116	
Completed treatment	448	71%
Did not complete	183	29%
Excluded from calc.	485	43%
Adult		
New admissions	6,005	
In Treatment	10,214	
Unduplicated people (open)	8,939	
Open admissions by drug of choice		
Alcohol	5,226	51%
Opiates	828	8%
Cocaine	1,381	14%
Methamphetamines	844	8%
Marijuana	1,491	15%
Other	444	4%
New admissions by Medicaid status		
Medicaid	2,767	46%
Not Medicaid	3,238	54%
Discharges (during year)	6,544	
Completed treatment	2,009	65%
Did not complete	1,093	35%
Excluded from calc.	3,442	53%
Opioid Treatment Programs		
New admissions	1,039	
In Treatment	3,352	
Unduplicated people (open)	3,111	
New admissions by Medicaid status		
Medicaid	751	72%
Not Medicaid	288	28%

Program Comparisons

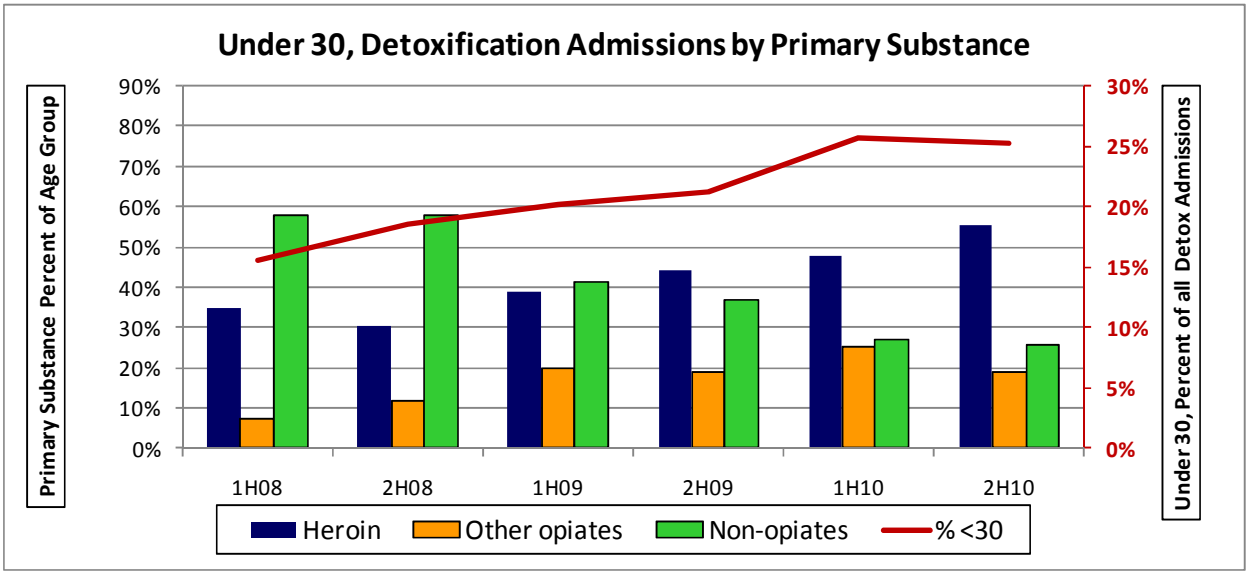
The table below shows data for the primary substance used by people admitted to different program areas and highlights differences among substances used.

Comparison of Primary Substance Used, January - December 2010

	Detoxification Center Admissions*	Outpatient Youth Admissions	Outpatient Adult Admissions
Total Number	3,391	1,694	10,214
Drug of Choice Percentage			
Alcohol	52%	26%	51%
Opiates	36%	1%	8%
Cocaine	7%	1%	14%
Methamphetamines	2%	2%	8%
Marijuana	2%	68%	15%
Other	1%	2%	4%

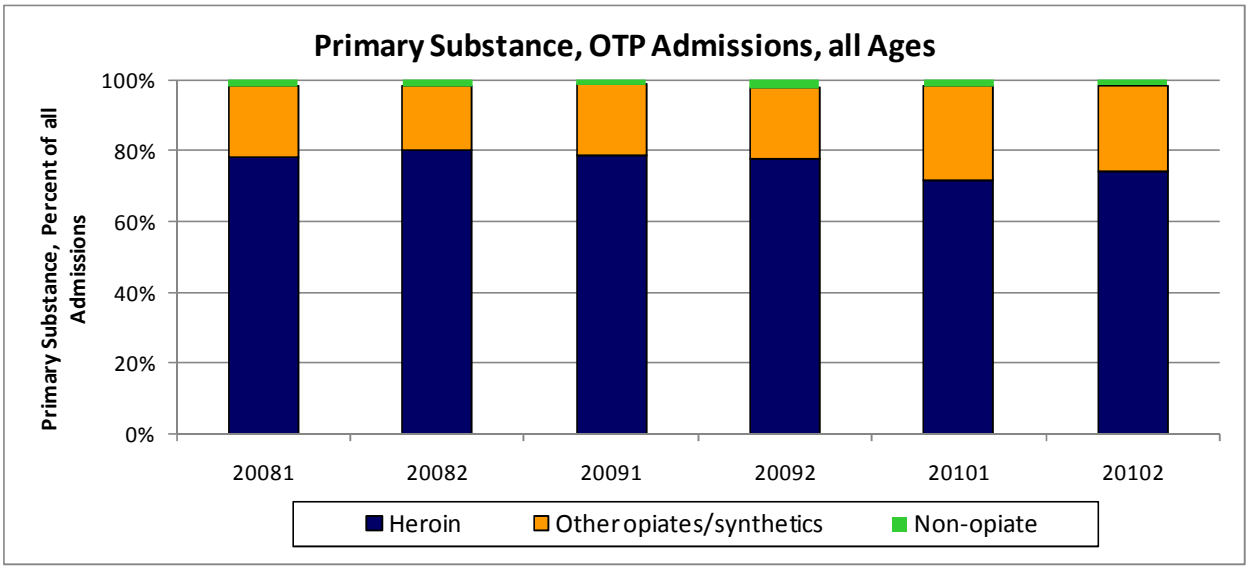
There is a dramatic difference between the Youth and Adult Outpatient identification of marijuana the primary substance used.

As noted earlier, the percentage of people admitted for detoxification whose primary substance used is an opiate has increased over the last four quarters, while the percentage using alcohol has declined. This change has been driven by two factors that are visible in the following chart: an increase in the number and percentage of young adults under 30 entering detoxification services; and increased use of heroin or other opiates among detoxing youth and young adults.



This chart, which separates "Opiates" into heroin and other opiates, also illustrates another trend: although heroin is the most frequent opiate used by those who enter detoxification services, other opiates besides heroin are becoming more common as the primary substance used by this treatment group.

Despite the striking changes seen above in the use of opiates by those starting detoxification, relatively little change has occurred over this three year period in the overall use of opiates by adults entering outpatient treatment or opioid treatment programs. However, a similar change to that seen with detoxification has occurred for opioid treatment programs (OTP): the percentage of those who use heroin has declined while the percentage whose primary substance is other opiates has increased from 2008 through 2010 as shown in the following chart.



Unlike detoxification admissions, OTP admissions did not shift toward a younger age group during this reporting period. Because there was an increase in other opiates among the approximately 26 percent of OTP clients who are under 30, the change in primary substance used for OTP clients is still evident above although it is a smaller change than that for detoxification clients.

These data are consistent with the "Seattle-King County Drug Trends 2010" report from the University of Washington, Alcohol and Drug Institute, which indicates that prescription opiate abuse is on the rise in King County, particularly among young adults, and that non-heroin/non-morphine opiates have been the leading cause of drug-related death in King County since 2005, and surpassed traffic fatalities as a cause of death in Washington State in 2008.

Demographic Detail, January – December 2010

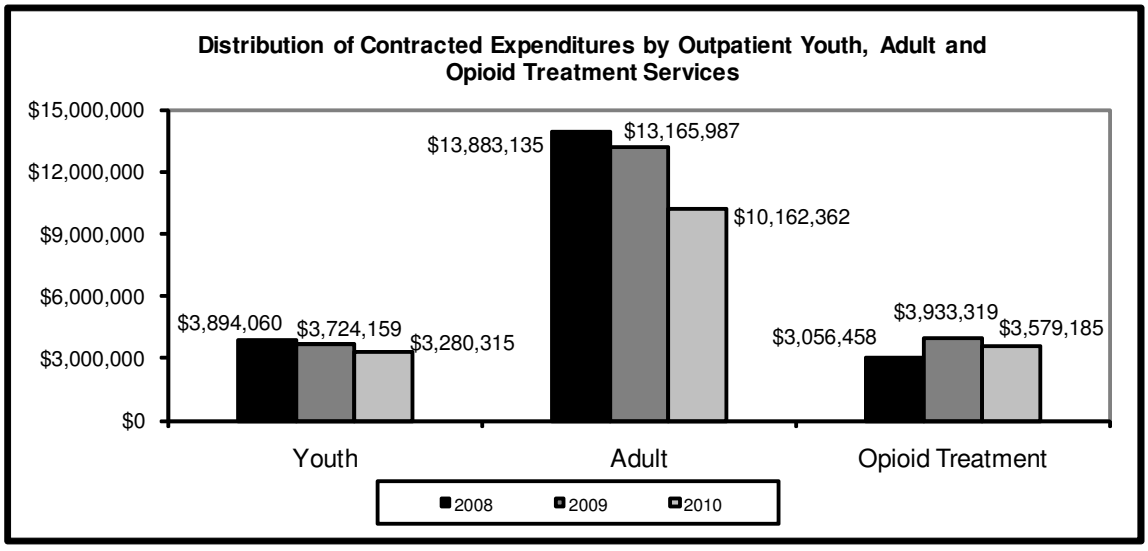
					Outpatient			King County Residents Below Fed. Pov. Level	
	Prevention	Sobering	Detox	ICS	Youth	Adult	Opioid Tx.	Youth (12 - 17)	Adult (over 17)
Unduplicated people served	2,784	2,091	2,435	99	1,564	8,939	3,111	13,941	130,809
Gender									
Number of people									
Male	1,223	1,801	1,746	85	1,089	5,966	1,665	7,178	59,047
Female	1,560	254	689	14	475	2,973	1,446	6,763	71,762
Percent of all served									
Male	44%	86%	72%	86%	70%	67%	54%	51%	45%
Female	56%	12%	28%	14%	30%	33%	46%	49%	55%
("Unknown gender" counts are not included)									
Race/ethnic group:									
Number of people									
African American	352	511	448	22	233	2,019	322	3,430	16,509
Asian/Pacific Islander	366	44	54	4	114	593	58	2,147	19,273
Caucasian/ White	1,381	870	1,442	54	650	4,504	2,224	6,009	82,073
Multi-racial	179	44	68	1	116	357	83	1,080	5,161
Native American	59	290	124	11	54	520	94	123	2,374
Other/ Unknown	447	332	299	7	397	946	330	1,152	5,419
Percent of all served									
African American	13%	24%	18%	22%	15%	23%	10%	25%	13%
Asian/Pacific Islander	13%	2%	2%	4%	7%	7%	2%	15%	15%
Caucasian/ White	50%	42%	59%	55%	42%	50%	71%	43%	63%
Multi-racial	6%	2%	3%	1%	7%	4%	3%	8%	4%
Native American	2%	14%	5%	11%	3%	6%	3%	1%	2%
Other/ Unknown	16%	16%	12%	7%	25%	11%	11%	8%	4%
	100%	100%	100%	100%	100%	100%	100%	100%	100%
Hispanic origin:									
Number of people									
Hispanic origin	411	208	149	9	435	836	182	2,623	14,994
Not Hispanic origin/Unkno\	2,373	1,883	2,286	90	1,129	8,103	2,929	11,318	115,815
Percent of all served									
Hispanic origin	15%	10%	6%	9%	28%	9%	6%	19%	11%
Not Hispanic origin/Unkno\	85%	90%	94%	91%	72%	91%	94%	81%	89%
	100%	100%	100%	100%	100%	100%	100%	100%	100%

(Percentages may not add up to 100% because of rounding)

Financial Summary

King County Substance Abuse Fund
2008 - 2010 Actuals
Financial Plan

	2008 Actual	2009 Actual	2010 Actual
Beginning Fund Balance	**2,419,423**	**2,897,187**	**3,779,516**
Revenues			
Licenses & Permits	0	0	0
Federal Grants	6,481,269	8,709,395	4,492,615
State Grants	14,187,246	11,684,814	12,141,575
Intergovernment Payment	1,170,582	1,191,409	1,141,326
Charges for Services	711,003	396,513	474,043
Miscellaneous	124,292	52,470	37,644
Other Financing Sources	187,809	0	0
Current Expense	3,217,189	3,166,986	0
Total Revenues	**26,079,390**	**25,201,587**	**18,287,202**
Expenditures			
Administration	(2,456,563)	(2,635,653)	(2,078,560)
Housing Voucher Program *	(510,182)	(419,781)	0
Treatment	(21,706,250)	(20,240,312)	(15,378,220)
Prevention Activities	(928,631)	(1,023,512)	(968,568)
Total Expenditures	**(25,601,626)**	**(24,319,258)**	**(18,425,348)**
Other Fund Transactions			
Adjustment Prior Yr Expenditures			
DCFM Energy Surcharge Refund			
Total Other Fund Transactions	**0**	**0**	**0**
Ending Fund Balance	**2,897,187**	**3,779,516**	**3,641,370**



Appendices

Appendix A. Data Sources

This appendix describes the data sources used for the Chemical Dependency Performance Indicators Report (CDPIR) and issues around the quality, meaning and availability of the data. It also includes specific notes about the data presented for different program areas.

Data Sources

The data included in this report come from four broad types of sources:

- Summary data furnished by service providers. Such data are used for Emergency Services Patrol.
- A database developed by MHCADSD that is used by the Dutch Shisler Sobering Support Center and Involuntary Commitment Services to collect data for those programs.
- The State Prevention database that contains data from contracted providers about individuals who participate in multiple episode prevention programs.
- The State TARGET database that contains data from contracted providers about individuals and their treatment services. TARGET data are used for the Detoxification Center and Youth, Adult and Opioid Treatment Program outpatient treatment portions of the CDPIR. (Although the Sobering Support Center also submits data to the TARGET system, those data are not used in this report because only minimal TARGET data are collected for sobering services.)

Race/Ethnicity/Hispanic Origin Data Issues

Among the programs that are included in this report, there are a number of differences in how data about race, ethnicity and Hispanic origin are collected and/or reported. To combine the data into a single consistent format, the following decisions were made:

- The "race/ethnicity" data reported for all program areas is presented using a single set of categories.
- The categories chosen are four commonly identified broad "race/ethnicity" groups (Black/African American, White/Caucasian/European American/Middle Eastern,
  Asian/Pacific Islander and Native American/Alaska Native) and two other groups (Multi-racial and Other/Unknown).
- In those areas where the data collection system allowed more than one choice per person, any individual with data that "rolled up" into two or more different broad groups is counted as "Multi-racial" (White and Chinese, which rolled up to White and Asian-Pacific Islander, is counted as "Multi-racial"; Korean and Chinese as "Asian-Pacific Islander").
- "Other" is grouped with "Unknown" into "Other/Unknown".

Program Specific Data Notes

Prevention

Prevention data shown in the report are from the state Prevention database. Providers report demographic data about individuals who participate in multiple session prevention programs but report only the total number of participants at single event prevention activities. Data about individuals include gender, age group, ethnicity and Hispanic origin.

Each multiple session program has a defined curriculum that is implemented with a registered group of participants who attend a prescribed number of sessions. Examples are Life Skills or the Nurturing Program. A single event is not an ongoing program but a prevention event that occurs once. Examples include a specific media campaign for graduation or prom time or a Health Fair.

Emergency Services Patrol

Individually identified data are not currently collected for this service.

Sobering Center

Data for services are entered into the MHCADSD chemical dependency database by Sobering Center staff using the Sobering Center application.

Detoxification Center

Data for services at the Detoxification Center are entered into the TARGET data system by Detoxification Center staff. This report is based on downloaded data from that system.

A separate TARGET admission is reported for each level of care. To represent the true volume of admissions regardless of changes in level of care, only one admission is counted when a person had a prior TARGET detoxification admission that ended the day before the new TARGET admission date.

TARGET requires that data be reported about each person's "primary substance used" as reported by the person admitted and evaluated by the clinician. The Detoxification Center is not required to report data about the drug(s) for which the person is receiving detoxification services.

TARGET allows multiple referrals to be reported; however, the CDPIR uses only one referral for each discharge. Discharge referrals were counted based on the following hierarchy that generally orders the choices according to the intensity of response that the referral represents: ADATSA, ITS, CD TX, Self-help, Housing and Other.

("Other" includes referrals for medical/dental, mental health and miscellaneous other resources.) Those discharges with multiple referrals are reported based on whichever of those referrals is the highest in this hierarchy. (Discharges that represent a transfer to a different level of care at the Detoxification Center are excluded to remain consistent with the admission data reported.)

Involuntary Commitment Services

Data for ICS referrals are entered into the integrated chemical dependency database by ICS staff using the ICS application. Data included are for referrals received and the disposition of referrals.

Outpatient Treatment: Youth, Adult and Opioid Treatment Programs

Data for all Outpatient programs are entered into the TARGET system by service providers; the CDPIR is based on those data.

The data used in this report are limited as follows:

- Only admissions where the TARGET "Fund Source" is "County Community Services" or there was a King County "Special Project Code" at some time during the admission are included. These conditions include admissions funded by MIDD. Those data indicate that the services are provided under contracts with King County.
- Data included for Youth and Adult are for the TARGET modalities of intensive outpatient, outpatient and MICA outpatient. Data for Youth are for all admissions where the client was under 18 on the admission date (for Adult, 18 or over).
- Data for Opioid Treatment Programs are for all admissions where the TARGET modality is "Methadone/Opiate Substitution Treatment".
- Opioid Treatment Program admissions that were essentially transfers to another treatment location (often with the same provider) were combined. Such continuous treatment episodes were counted as a new admission only for the period when the first admission started and were counted as only one admission for any period in which the combined admissions were open.

The treatment completion rate is computed using the following algorithm:

$$\frac{\text{\# of discharges with treatment completed}}{\text{number of discharges}}$$

Note that the denominator used to compute treatment completion rate includes only discharges for the following reasons: completed treatment, no contact/aborted treatment, not amenable to treatment, rule violation and withdrew against program advice.

Discharges for the following reasons are excluded from the calculation of treatment completion rate: client died, charitable choice, funds exhausted, inappropriate admission, incarcerated, moved, transferred to different facility, withdrew with program advice, administrative closure and other.

The statewide rates for treatment completion that are cited for Youth and Adult Outpatient Treatment are based on reports from the Treatment Analyzer, which contains TARGET data although it is different from the TARGET system. Those reports use the treatment completion algorithm described above. The reported results were calculated in each area (Youth and Adult) by running a statewide report and a King County report, then subtracting the numbers for King County from the statewide numbers for both the "number of discharges with treatment completed" and the "number of discharges". The rate was then calculated as shown above.

Appendix B. Glossary

A-CRA	Adolescent Community Reinforcement Approach
ACC	Assertive Continuing Care
ADATSA	The Alcohol and Drug Addiction Treatment and Support Act, which provides state-financed treatment and support to indigent people who are chemically dependent. ADATSA provides eligible people with inpatient and outpatient chemical dependency treatment and with limited financial support for housing and other needs.
AODPP	Alcohol and Other Drug Prevention Program
ATR	Access to Recovery
Biennial	Washington State's fiscal year is organized on a two-year basis, referred to as a biennium. Biennial quarters are one fourth of that period, or six months long. The biennium for this report began July 1, 2009 and ended June 30, 2011.
CD TX	Chemical dependency treatment.
CDP	Chemical Dependency Professional
CDPT	Chemical Dependency Professional Trainee
CPPW	Communities Putting Prevention to Work
CRA	Community Reinforcement Approach
DBHR	Washington State Division of Behavioral Health and Recovery
DSSC	Dutch Shisler Service Center
ESP	Emergency Services Patrol (see program description).
GAIN	Global Appraisal of Individual Needs. A standardized bio-psychosocial assessment tool for people presenting for substance abuse treatment.
GAIN-I	The GAIN instrument used for an initial comprehensive assessment.
GAIN SS	GAIN Short Screener. A quick tool used to screen for mental health and substance use diagnoses.

ICS	Involuntary Commitment Services (see program description).
JDCEP	King County Juvenile Drug Court Enhancement Project
KCCOP	King County Community Organizing Program
MHCADSD	The Mental Health, Chemical Abuse and Dependency Services Division of the King County Department of Community and Human Services.
MIDD	The Mental Illness and Drug Dependency Action Plan is a King County initiative funded with a one tenth of one percent sales tax to provide programs designed to stabilize people suffering from mental illness and chemical dependency, and to divert them from jails and emergency rooms by getting them proper treatment.
OTP	Opioid treatment program (see program description)
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, Referral to Treatment
SKCPH	Seattle-King County Public Health
TARGET	Treatment Assessment and Report Generation Tool is a data collection and reporting system that is maintained by the Washington State Department of Social and Human Services and contains data submitted by contracted treatment providers about the publicly funded chemical dependency treatment that they provide.
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
VOR	MHCADSD Mental Health Voices of Recovery

Appendix C. Program Providers

Provider	Prev.	ESP	Sober. Ctr	Detox	ICS	Outpatient		OTP
						Youth	Adult	
Alpha Center							x	
Asian American Chemical Dependency Treatment Services							x	
Asian Counseling Referral Service						x	x	
Auburn Youth Resources	x					x		
Catholic Community Services							x	
Center for Human Services	x					x	x	
Community Psychiatric Clinic						x	x	
Consejo Counseling & Referral Svcs						x	x	
Downtown Emergency Service Center							x	
Encompass	x							
Evergreen Healthcare							x	
Evergreen Treatment Services								x
Friends of Youth	x					x		
Girl Scouts-Western WA	x							
Greater Maple Valley Community Center	x							
Harborview Medical Center Addictions Program							x	
Integrative Counseling Services							x	
Intercept Associates						x	x	
Kent Youth and Family Services						x		
King County Emergency Services Patrol		x						
King County Involuntary Commitment Services					x			
Lifelong AIDS Alliance	x							
Muckleshoot Indian Tribe						x	x	
Navos							x	
Neighborhood House	x							
New Traditions							x	
Northshore Family and Youth Services						x		
Pioneer Human Services			x				x	
Recovery Centers of King County				x			x	
Renton Area Youth and Family Services	x					x		
Ruth Dykeman Youth and Family Services						x		
SafeFutures Youth Center	x							
SeaMar Community Health Centers						x	x	
Seattle Counseling Services						x	x	
Seattle Indian Health Board							x	
Snoqualmie Indian Tribe						x	x	
Sound Mental Health						x	x	
Therapeutic Health Services						x	x	x
Valley Cities Counseling and Consultation						x	x	
Vashon Youth & Family Services	x					x	x	
Washington Asian/Pacific Islander Families Against Substance Abuse (WAPIFASA)	x					x		
Youth Eastside Services						x		